GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

AUDIT OF THE HEALTH CARE SAFETY NET CONTRACT

CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL

OIG No. 02-1-2HC **October 4, 2002**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

October 4, 2002

Mr. James A. Buford
Acting Director
Department of Health
825 North Capitol Street, N.E.
Washington, D.C. 20002

Dear Mr. Buford:

Enclosed is the final audit report summarizing the results of the Office of the Inspector General's Audit of the Health Care Safety Net Contract (OIG No. 02-1-2HC). The audit was conducted at the request of a District of Columbia Councilmember.

As a result of our audit, we directed 11 recommendations to the Department of Health (DOH) for necessary action to correct the described deficiencies. We want to acknowledge that DOH has reacted positively to our identification of issues to improve the operations of the Health Care Safety Net Administration. DOH initiated corrective actions during the audit and continues to make improvements.

We request, however, that DOH reconsider its position on Recommendations 2 and 3 and provide additional responses to us by November 4, 2002. Additionally, we request DOH provide us target completion dates for planned corrective actions. The complete text of the DOH response is included in Exhibit C.

We appreciate the cooperation and courtesies extended to our staff during the audit. If you have questions, please contact me or William J. DiVello, Assistant Inspector General for Audits, at (202) 727-2540.

Sincerely,

Charles C. Maddox, Esq.
Inspector General

CCM/ws

Enclosures

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AUDIT OF THE HEALTH CARE SAFETY NET CONTRACT

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OVERVIEW

This report summarizes the Office of the Inspector General's (OIG) audit of the Health Care Safety Net contract (Contract). The audit was conducted at the request of a District of Columbia Councilmember who had concerns about the restructuring of D.C. General Hospital. That restructuring included the elimination of a portion of D.C. General Hospital functions and the addition of an integrated, neighborhood-based primary and preventive care network for residents, which is overseen by the District of Columbia Department of Health (DOH).

We want to acknowledge that DOH has reacted positively to our identification of issues to improve the operations of the Health Care Safety Net Administration. DOH initiated corrective actions during the audit and continues to make improvements.

DOH was directed by the Mayor to develop a fiscally responsible, service delivery oriented, and culturally competent health care system for the District of Columbia (District). Approximately $90 million was appropriated for that task. As a result, the District entered into a contract with the Greater Southeast Community Hospital Corporation (GSCHC) to form the D.C. Health Care Alliance (Alliance). The Alliance, which consists of GSCHC and a group of health care providers that are subcontractors to GSCHC, is charged with assuring comprehensive and quality health care for the city's indigent population. The Health Care Safety Net Administration (HCSNA) was developed within DOH to oversee and manage the implementation and ongoing operations of the Alliance. In light of HCSNA's role relative to the contract between the District and GSCHC, we refer to the agreement as the HealthCare Safety Net Contract throughout this report.

CONCLUSIONS

The report contains two findings that include the details supporting the conditions we observed and documented. First, we found that DOH did not maintain the proper level of contract oversight because positions within HCSNA were not filled in a timely manner. As a result, the District has little assurance that GSCHC is in compliance with the contract terms or that overall goals, such as the estimated expected patient workloads, are being met. Additionally, the original contract estimate was overstated. We also determined that the contract may be over-funded and that there is a possibility that as much as $10 million may be reduced from annual funding for this contract and put to better use within DOH.

Second, we found that Alliance enrollees are not properly screened for program eligibility because procedures to verify enrollment information are not always followed and there is limited oversight by DOH to ensure that this important function is properly completed. As a result, we found that all enrollees, who appear to be eligible for Medicaid, were not referred for Medicaid screening by the Income Maintenance Administration (IMA) as required by the Contract. We also found that approximately $289,000 in medical charges were incurred by

EXECUTIVE DIGEST

Alliance members who were actually covered by other insurance, and about 2,600 Alliance members were enrolled using invalid Social Security numbers. Forty of those invalid numbers matched the Social Security numbers of deceased individuals. As a result, it is highly probable that the Alliance incurred charges for individuals who are not District residents and do not satisfy the income requirements of the program.

The Councilmember requesting this review also asked for, and this report contains, information on levels of trauma services provided under the contract and an analysis of emergency room visits since the Alliance program was initiated. The detailed information is shown in Exhibit A, "Other Matters of Interest."

MANAGEMENT ALERT REPORT

On April 9, 2002, our Office issued a Management Alert Report (MAR 02-A-2HC) in which many of the above discrepancies were brought to management's attention. The MAR was addressed to the Director of DOH, and it discussed, among other issues, contract oversight, verification of Alliance membership rolls, and the possible $10 million funding surplus. In fact, we informed the Director of the possible funding surplus in a meeting on March 7, 2002, when we discussed our findings. These issues were incorporated in our report.

SUMMARY OF RECOMMENDATIONS

We directed 11 recommendations to the Director of DOH:

- Ensure that total contract oversight is provided by positions created within HCSNA and that those positions are promptly filled with the most qualified applicants.

- Collect any overpayment for travel or travel expenses paid to William M. Mercer, Inc., which exceeds the maximum contract amount. In addition, ensure that any amounts billed, but not yet paid, for travel exceeding the contract maximum are rejected.

- Review the billed hours for September 2001 for the William M. Mercer, Inc. contract and recover any payments for on-site work which cannot be proven.

- Review and adjust the expected service levels shown in the Contract to reflect more realistic expectations based on actual service levels collected to date.

- Calculate the exact funding surplus, reduce the contract funding by that amount, and put the funds to better use within the Department.

- Require the contractor to comply with the contract provision to operate a 24/7 hotline to answer questions concerning the Alliance program or change the Contract to a

EXECUTIVE DIGEST

reduced service level with appropriate adjustment to contract price to reflect reduced service requirements.

- Require GSCHC to train and ensure that Alliance enrollment specialists understand screening procedures and are, in fact, following those procedures when performing the enrollment service. Also, ensure that GSCHC is re-screening members at the required 6-month intervals to determine whether they remain eligible.

- Ensure that GSCHC establishes procedures to determine the Medicaid status of all applicants before admittance to the Alliance program is granted. In addition, recover all payments made by the Alliance for patients covered by the Medicaid program at the time health-care service was rendered and remit recovered funds to the District.

- Ensure that GSCHC determines that applicants for Alliance membership are not eligible for Medicaid coverage before Alliance eligibility is declared.

- Require GSCHC to use a tax return, for those Alliance applicants who are required to file one, as proof of income and residence for Alliance insurance.

- Periodically review Alliance membership rolls and ensure that enrollees meet all membership requirements. Random sampling techniques may be employed.

MANAGEMENT RESPONSES AND OIG COMMENTS

On October 2, 2002, DOH provided response to the recommendations in the draft audit report. Generally, DOH officials agreed with the report, most of its conclusions, and nine of the eleven recommendations. The DOH response included actions taken, planned, and with a few exceptions the target dates for completion of planned actions to correct noted deficiencies. We consider the DOH response and actions taken to be responsive to nine audit recommendations. However, DOH disagreed with Recommendation 2, to collect any overpayment for travel or travel expenses paid to William M. Mercer, Inc. which exceeds the maximum contract amount and to ensure that any amounts billed, but not yet paid, for travel exceeding the contract maximum is rejected. DOH also disagreed with Recommendation 3, to review the billed hours for September 2001 for the William M. Mercer, Inc. contract and recover any payments for on-site work which cannot be proven. We request DOH to reconsider its position on Recommendations 2 and 3 and provide an additional response by November 4, 2002. The complete text of the DOH response is included at Exhibit C. We also received comments from William M. Mercer, Inc. in response to the draft report. We took these comments into consideration in preparing the final report. The complete text of William M. Mercer, Inc. comments is at Exhibit D.

INTRODUCTION

BACKGROUND

The OIG has completed an audit of the Health Care Safety Net contract. The audit was conducted at the request of a Councilmember who had concerns about the contract and the ability of DOH to ensure a transition to a new health care system with no disruption to patient services as they existed under the former system, which was operated by the D.C. Health and Hospitals Public Benefits Corporation (PBC).

PBC. In 1996, the PBC was established in an attempt to, among other things, increase the efficiency of health care services provided to D.C. residents while reducing expenditures. On April 9, 1997, the Health and Hospitals Public Benefits Corporation Act of 1996 was enacted as D.C. Law 11-212. Pursuant to this legislation, health care functions performed by D.C. General Hospital and the community clinics, which were under the auspices of the Department of Human Services' Commission of Public Health, were transferred to the PBC. The PBC had a separate and legal existence within the District and was subject to all laws and regulations of the District government, with the exception of certain personnel and procurement policies. Final approval of operational responsibility and title over all D.C. General Hospital and community clinic assets transferred to the PBC, effective October 1, 1997. However, the PBC continuously experienced operating problems and was forced to borrow $109 million from the District to continue operating through fiscal year (FY) 2000.

In a November 14, 2000, memorandum to the Mayor, the Chairman of the Council of the District of Columbia, the Chairman of the District of Columbia Financial Responsibility and Management Assistance Authority (Authority), and the Chairman of the PBC, the District's Chief Financial Officer (CFO) issued an urgent plea for action in regard to the PBC. The CFO's memorandum stated that, "at its current rate of spending, PBC will exhaust its $45.3 million FY 2000 subsidy by the middle of March 2001." The CFO also stated that if money were to be set aside to maintain the clinics, D.C. General Hospital may be forced to close even sooner. As a result of this financial crisis, the Authority enacted the Health Care Privatization Amendment Act of 2001, D.C. Law 14-18, effective July 12, 2001. *See* 48 D.C. Reg. 9088 (Oct. 5, 2001). This legislation ordered the closure of the PBC and transferred its functions to the District's Department of Health (DOH).

In order to ensure continued health care services, DOH was given the responsibility of overseeing the PBC phase-out. DOH was then directed to establish an alternative publicly financed health-care delivery system to provide the equivalent volumes and types of health-care services formerly provided by the PBC. The new system would in effect provide a health-care safety net for uninsured or underinsured District residents. DOH was also directed to ensure that the health-care services met a minimum standard of quality and user accessibility. On April 12, 2001, the District entered into a contract (Contract) with Greater Southeast Community Hospital Corporation (GSCHC) to deliver the health-care services required.

INTRODUCTION

The Health Care Safety Net Administration (HCSNA) was established under DOH to oversee the contract. The Mayor also appointed an outside commission, the Health Services Reform Commission (HSRC), to perform additional and independent contract oversight. (Contract oversight is discussed in Finding 1.)

Health Care Safety Net Contract. The Contract period contains a 5-year initial term followed by two 2-year option periods. It contracts for medically necessary health-care services to be delivered to District residents who are without health insurance coverage and whose family income is at or below 200 percent of the federal poverty level. For a family of one, the maximum income is $17,180 and for a family of two, the maximum income is $23,220. The entire income eligibility scale is shown below.

Table 1. Income Eligibility Scale

Family Size	Annual Income	Monthly Pay	2 Week Pay	Weekly Pay	Hourly Pay
1	$17,180.00	$1,431.67	$660.77	$330.38	$8.26
2	$23,220.00	$1,935.00	$893.08	$446.54	$11.16
3	$29,260.00	$2,438.33	$1,125.38	$562.69	$14.07
4	$35,300.00	$2,941.67	$1,357.69	$678.85	$16.97
5	$41,340.00	$3,445.00	$1,590.00	$795.00	$19.88
6	$47,380.00	$3,948.33	$1,822.31	$911.15	$22.78
7	$53,420.00	$4,451.67	$2,054.62	$1,027.31	$25.68
8	$59,460.00	$4,955.00	$2,286.92	$1,143.46	$28.59

The Contract requires GSCHC to provide health care services that include:

- primary and preventive health services;
- emergency and Level 1 trauma services;
- inpatient and outpatient hospital services;
- specialty physician services;
- language translation services;
- disease management;
- diagnostic testing and evaluation;
- dental care;
- school health services; and
- corrections health care services.[1]

[1]Alliance members in the corrections system may not meet the full criteria as required by the Contract.

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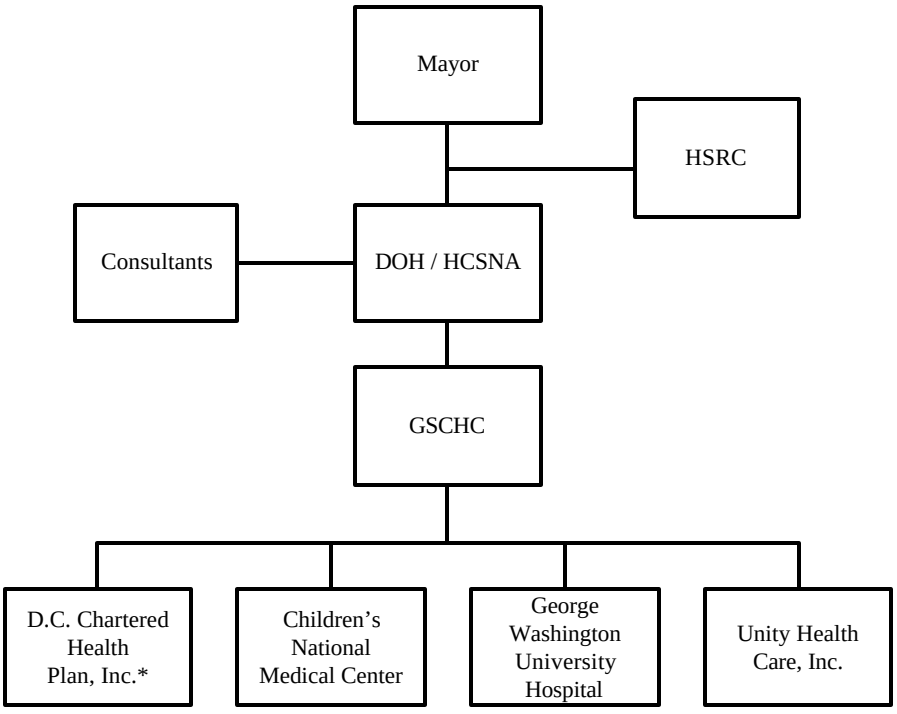
GSCHC is also required to perform program enrollment and data management. GSCHC must provide monthly, quarterly, and annual reports regarding volume, costs, quality, and access to services, as specified by the District. In addition, the Contract estimates the expected annual volume of services. For example, the contract estimates 4,560 inpatient hospital admissions, 40,280 emergency room visits, and 39,192 primary care service visits. The original contract award amount of $90 was based, in part, on the estimated annual volume of services. (Estimated workloads are discussed in Finding 1.)

The annual cost of the Contract is $79.5 million. In addition, there is a one-time funding payment of $13.3 million, which is comprised of $11.8 million for facility renovation and $1.5 million for start-up support. (Annual contract costs are discussed in Finding 1.)

To meet the requirements and accomplish the goals established by the Contract, a group of health-care providers were subcontracted by GSCHC. Together, GSCHC and this group are known as the Alliance, and they are charged with assuring comprehensive and quality health-care for the District's indigent population. The diagram below identifies the Alliance members and shows the oversight chain for the Contract.

Diagram 1. Alliance Members



* D.C. Chartered Health Plan, Inc. also has agreements with other health care providers, including Providence Hospital and Howard University Hospital.

INTRODUCTION

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit objectives were to determine whether selected hospital and health-care services were delivered at reasonable cost within the terms and conditions of the Contract. We also examined DOH's oversight of the Contract. Based on a request by a D.C. Councilmember, we developed information on levels of trauma services and analysis of emergency room visits. This information is shown in Exhibit A, "Other Matters of Interest." The audit period generally covered July 2001 through May 2002.

To accomplish our objectives, we examined financial reports, billing documents, program applications, invoices, and contracts and other pertinent information. We interviewed DOH management personnel, Alliance management personnel, D.C. Fire and Emergency Medical Service (DCFEMS) personnel, D.C. Hospital Association personnel, Prince George's Hospital Center (PGHC) management, American College of Surgeons (ACS) personnel, and D.C. Women's Hospital management. We also interviewed management personnel from every member of the Alliance. The audit was made in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

FINDING 1: CONTRACT OVERSIGHT

SYNOPSIS

DOH did not maintain a proper level of oversight regarding the Health Care Safety Net contract. A proper level of oversight was not maintained because HCSNA did not fill key oversight positions. In addition, DOH did not properly oversee the efforts of a consultant hired to assist HCSNA with contract oversight. As a result, the District has little assurance that: (1) GSCHC is in compliance with all of the Contract terms; (2) the Contract goals are being met; (3) the estimated patient workloads reflected in the Contract are valid; and (4) the annual $79 million contract estimate is the correct amount to appropriate each year. In addition, DOH did not realize that the Alliance program could possibly be over-funded by approximately $10 million. Further, DOH overpaid the consultant by $194,597 for travel expenses and paid for questionable services, which could total as much as $100,000.

DISCUSSION

In April 2001, the District entered into a contract with GSCHC to provide a health-care delivery system for residents who were uninsured or underinsured. In effect, this health-care system would be a safety net for those who could not qualify for other health insurance because of their income level or other circumstances. The Contract required GSCHC to provide, or cause to be provided, the equivalent volumes and types of health-care services as previously provided under the PBC. To ensure that the contract was monitored, the District devised a two-pronged approach. First, DOH created a new division called HCSNA to review contract data, monitor compliance with the contract, and hold GSCHC accountable to all contract provisions. Additional oversight was to be provided by HSRC. This was a 38-member commission appointed by the Mayor on June 7, 2001, and comprised of health-care professionals, government officials, and local business leaders. Neither HCSNA nor HSRC have proven to be effective in the oversight and monitoring of the Contract.

Health Care Safety Net Administration

When HCSNA was given the responsibility to monitor the new health reform initiative and the Contract, several requirements became paramount. Key considerations were to implement reform with the least disruption, ensure appropriate contractor infrastructure, ensure budget compliance by GSCHC and DOH, and support the program operations and planning. HCSNA would formally be charged with responsibility for managing, monitoring, and evaluating the performance of GSCHC. It would also monitor program community outreach, clinical management of the contract, and most importantly, contract compliance by GSCHC and the subcontractors.

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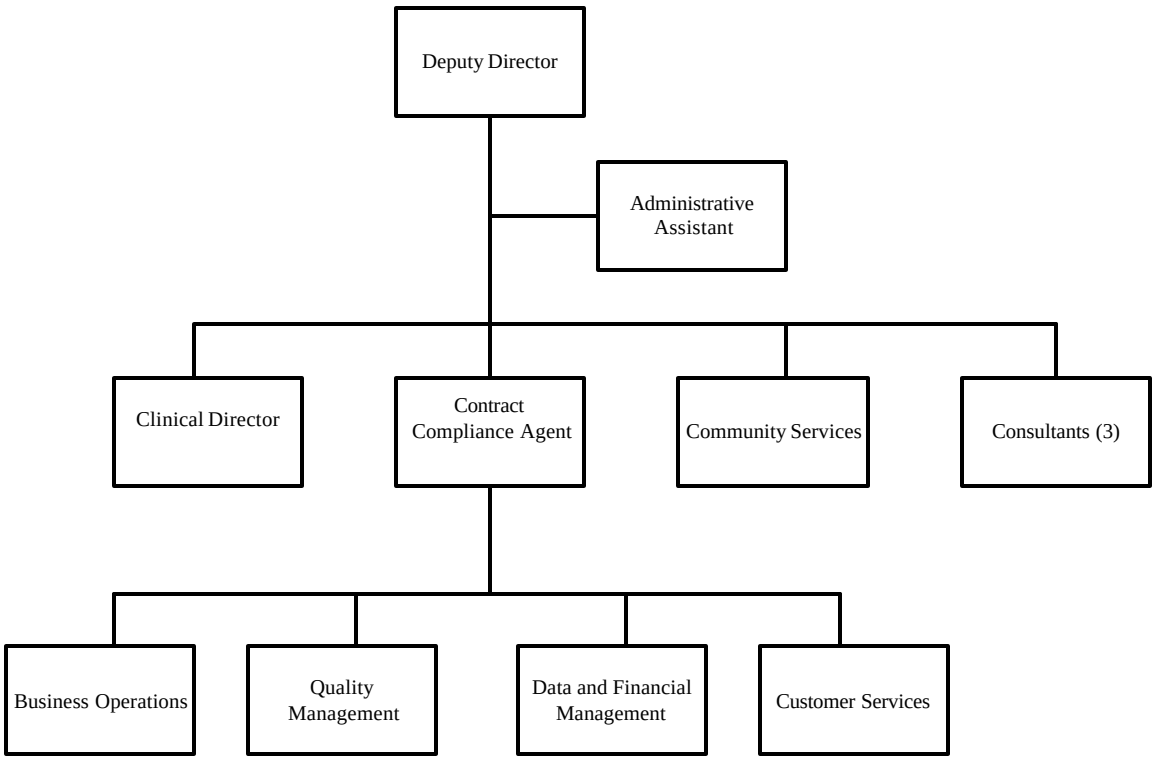
The organizational structure of HCSNA was originally formulated as follows:

Diagram 2. HCSNA Original Organization Structure



In May of 2001, DOH appointed a Deputy Director (MSS-16) to head HCSNA. During the next 6 months, only 2 positions under the Deputy were filled. The first was an Administrative Specialist (DS-12), who primarily served as Assistant to the Deputy Director and whose major duties and responsibilities included attending meetings with the Deputy and keeping track of pertinent issues, preparing documents for signature, reviewing correspondence, etc. The second position filled was a Special Assistant (DS-13) with major duties and responsibilities very similar to the Administrative Specialist, with the exception of additional work in the area of forecasting budget and service utilization rates and developing reports on those areas as they relate to the Contract. In addition, a consulting group was hired to work with HCSNA to develop reporting systems and perform studies for DOH, as needed. However, key positions such as the Contract Compliance Agent, Clinical Director, and Community Services Director were never filled during this critical start-up stage of the Contract. DOH briefing charts describe these unfilled positions as follows:

FINDINGS AND RECOMMENDATIONS

Contract Compliance Agent will:

- provide financial, information systems and quality management expertise;
- develop DOH infrastructure for ongoing program operations; and
- provide major areas of support such as readiness reviews, information systems development, onsite staff support, maintenance of effort development, and system support.

Clinical Director will:

- monitor all clinical aspects of the contract;
- interface with the provider community;
- be final arbitrator for all clinical disputes;
- establish clinical standards and protocols; and
- establish and direct clinical committees.

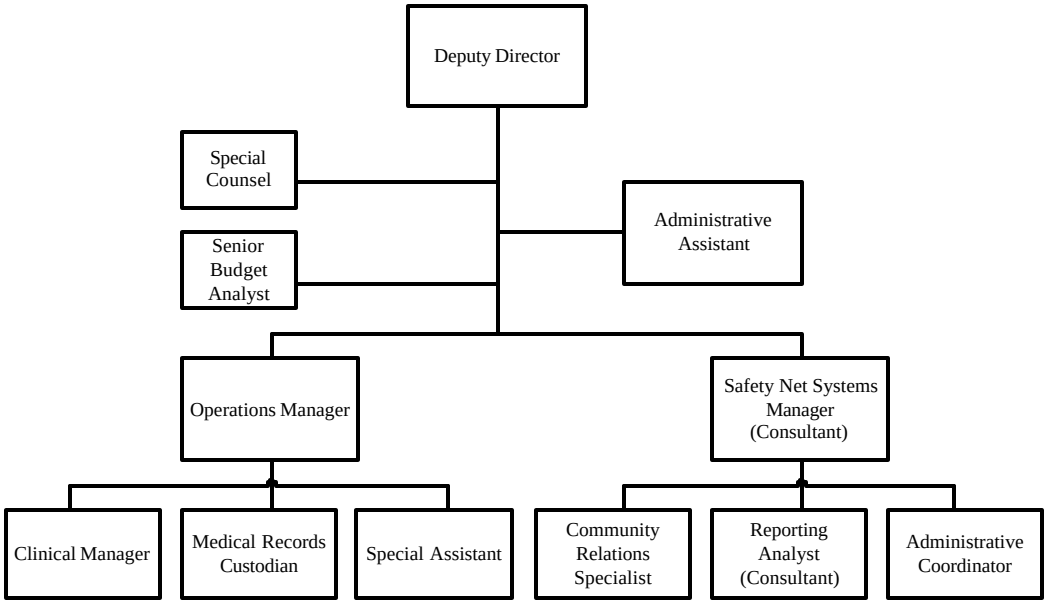
Community Services Director will:

- be primary interface with the community;
- perform problem resolution;
- monitor access to services;
- prioritize community needs; and
- assure community input.

The original HCSNA Deputy Director, who was hired in May 2001, resigned 6 months later in November 2001, and that position remained unfilled for about 1 month until a new Deputy was hired in December 2001. The three critical oversight positions remained unfilled, and a revised HCSNA organizational chart, developed by the new Deputy, no longer reflects these key positions. The new organization is structured as follows:

FINDINGS AND RECOMMENDATIONS

Diagram 3. HCSNA Current Organization Structure



The above positions have been advertised and, as of June 2002, are starting to be filled. However, it has been almost 1 year since the Contract was signed. During this time, critical contract planning and infrastructure development were taking place and decisions were being made regarding reporting, enrollment, and billing procedures without the benefit of a full DOH oversight staff. In fact, with a staff of two, it was extremely difficult, if not impossible, for a Deputy Director to oversee and manage a contract as large, complex, expensive, and as important as the Health Care Safety Net contract.

The HCSNA should take steps to ensure that the newly created oversight positions will provide complete contract coverage and are filled as soon as practical.

Health Services Reform Commission

When the 38-member HSRC was appointed by the Mayor in June 2001, the Commission promised that, in addition to DOH oversight, they too would actively oversee the Contract as part of a two-tiered approach established by the city to monitor contract compliance. However, between June and December 2001 the Commission met only twice. During that time period, Commission members complained that they received no information about the Contract and held no meeting to review anything GSCHC was doing. To complicate matters even further, in September 2001, the Commission Chairman resigned. His seat remained vacant for about 3 months until December 2001, when a new Chairman was appointed. As a result, the contract received little or no oversight from HSRC during the critical start-up period, and the two-tiered contract oversight approach did not materialize. Since the new

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Chairman arrived, meetings have taken place on a regular basis, and the committee as a whole has started to plan, organize, and assume their oversight role.

The lack of contract oversight by both DOH and HSRC during the start-up phase of the Contract has allowed problems to occur that directly impact the program. The problems pertain to DOH oversight consultants, annual patient workload, and contract requirements.

DOH Oversight Consultants

The DOH awarded contracts to two consulting firms in order to carry out its oversight responsibility for the heath-care safety net program. In addition, the District of Columbia Financial Responsibility and Management Assistance Authority (Authority) entered into a $1.7 million sole source contract with William M. Mercer, Inc., in May 2001 for a portion of that support. Among other things, the consultant was required to develop databases, information systems, and clinical and financial protocols to support performance monitoring. They were to provide three onsite staff members on a daily basis to monitor contract performance, analyze reports, and assist in day-to-day program management. The staff members were to perform the day-to-day functions of the HCSNA until staff was hired and appropriately trained to perform in that capacity. Mercer was to transfer their knowledge to the new staff.

We reviewed the consultant's travel expense ledger for a 120-day period from June through September 2001 and found that for more than one third of that time (42 days), fewer than 3 employees were present on site. During September 2001, the consultant was reimbursed nearly $500,000 for billable-hour charges made to DOH. About $185,000 of billable-hour charges were attributable specifically to the onsite monitoring effort. We reviewed the consultant's September 2001 invoices against the expense ledger in an effort to reconstruct and reconcile the $185,000 of billable hours to the travel days spent in the District. According to the consultant's travel expense ledger, only two of the eight (out-of-town) employees spent a sufficient number of days in the District to warrant reimbursement. DOH management apparently did not provide an acceptable level of monthly oversight and review of the consultant's invoices, which resulted in the potential for erroneous and excessive charges. HCSNA should verify the hours in question and take steps to recover any overpayments, which could total as much as $100,000.

More obvious was the consultant's overrun of travel expenses. The Contract specifically limits the consultant to a maximum of $50,000 of travel and expenses in FY 2001 and the same amount in FY 2002. We found that in FY 2001, for a period of less than 5 months, the consultant was reimbursed $164,343 for travel and expenses. The travel reimbursement is $114,343 in excess of the contract allowance. Through March of 2002, the consultant submitted vouchers for, or has been paid, $130,254 in travel and expenses. In just 6 months of FY 2002, the consultant was paid $80,254 above the FY 2002 entitlement. For both years, the consultant received $194,597 in overpayments for travel expenses.

FINDINGS AND RECOMMENDATIONS

HCSNA should take steps to collect all overpayments for travel and travel expenses that were paid in excess of contract maximum amounts and ensure that any amounts billed in excess of contract maximum allowances are rejected.

Estimated Annual Patient Workloads

When District officials were determining the annual cost of the Contract, one of the important factors used was an estimate of expected service levels. Officials knew that the Contract would call for services to be delivered at the same historical levels as under the PBC, but the problem was predicting just how many eligible uninsured and underinsured persons would make themselves available for health-care service. It was decided that the levels of patients seen by the PBC would be the starting point and, as a safety factor, a percentage of that figure would be added in each category of service. As a result, the Contract reflects a 34 percent overall increase (over PBC levels) in the estimated annual volume of services as follows:

- inpatient hospital admissions: 4,560 admissions (55 percent increase);
- emergency room visits: 40,280 visits (20 percent increase);
- ambulatory surgeries: 2,144 procedures (20 percent increase);
- outpatient-hospital visits: 46,015 visits (20 percent increase);
- primary care visits: 39,192 visits (20 percent increase); and
- dental visits: 15,811 visits (20 percent increase).

These numbers reflect service volumes the Alliance is expected to be able to satisfy, under the terms of the Contract, should they materialize.

Early in the contract period, Chartered Health Plan, Inc. (Chartered) was hired as a subcontractor to handle the enrollment of people into the new health-care system. The PBC rolls were reviewed in an attempt to purge those who did not meet the established criteria of residency, income levels, and the lack of third-party health insurance coverage. Chartered attempted to contact all former PBC patients and required them to establish their eligibility under the new criteria. In addition, enrollment specialists were permanently stationed at the Alliance hospitals and clinics to enroll new patients. (Enrollment problems are discussed in Finding 2.)

However, removal of PBC patients who did not meet the enrollment criteria presented DOH with another problem, which, due to a lack of contract monitoring, was not corrected. The base numbers (PBC rolls) used to project service volumes quickly eroded and, as a result of the additional 34 percent added to the calculation, caused the original contract estimate to become greatly overstated. In fact, we reviewed the actual volume for 3 of the categories for

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a 6-month period ending December 31, 2001, and found that actual versus expected levels differed by as much as 69 percent, as shown in the following chart.

Table 2. Actual Volume Verses Expected Levels

Type of Visit	Expected Service Levels	Alliance Reported Service Levels	Difference	Percent Difference
Inpatient	2,280	894	1,386	(61%)
Emergency	20,140	6,141	13,999	(70%)
Primary Care	19,596	13,911	5,685	(29%)

HCSNA should review and adjust the expected service levels, as currently reflected in the Contract, to more realistic levels using the actual levels experienced to date as a guideline.

Annual Contract Funding

Another result of the overestimated expected service levels is the possible overestimation of annual contract funding. As required, an accounting firm was retained by the District and asked to review several issues in regard to payments received by GSCHC during the first 6 months of operation. First, they were to determine whether payments for health-care services, as defined in the Contract, were made in accordance with the rates set forth in the Contract. Secondly, they were to reconcile budget and actual costs and identify any reconciliation adjustments periodically required by the Contract. In addition, they were asked to prepare reports showing the effects of any budgetary reconciliation adjustments, to include the computation of any amounts owed by one party to the other. The report was issued in April of 2002 and identified a net program funding surplus in excess of $10.4 million. The reconciliation did not review certain aspects of the Contract such as school health services or correctional health services and, therefore, the actual $10.4 million, in our opinion, may be somewhat high. We believe that even when school and correctional health services are added, the funding surplus will still have the potential to reach or exceed $10 million. This surplus is based on the funds provided to GSCHC during the first 6 months of the Contract and the actual services provided by GSCHC.

While the accounting firm did not determine the "root cause" of the program funding surplus, it is apparent that overestimating the expected contract services could have played a large part in creating such a condition. It is also apparent that had the two contract oversight activities created by the District actually been functioning properly during this time period, there would have been a chance to detect the surplus much earlier.

Since the actual funding surplus is currently unknown, it is important that HCSNA act quickly to bring certainty to this issue. In performing its oversight role, HCSNA should calculate the exact funding surplus by adding other contract obligations such as the aforementioned school and correctional health services. Other factors, such as any

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anticipated funds needed for reimbursement to a non-Alliance hospital for services provided to an Alliance member, should also be taken into consideration. The final net funding surplus dollar amount should be reported to DOH and that amount should be reduced from the annual Contract funding. DOH should then put those funds to better use within the Department.

Contract Requirements

Exhibit A, Section 5.12.2 of the Contract provides for the establishment of a hotline to answer questions about the Alliance program. The Contract states that GSCHC shall maintain and staff a 24-hour, 7 days-a-week (24/7) toll-free dedicated hotline to respond to enrolled Eligible Uninsureds' inquiries, complaints, and problems raised regarding services. If the caller is not satisfied, GSCHC must ensure that the call is referred to the appropriate individual for follow-up and or resolution within 48 hours of the call.

We found that GSCHC subcontracted the Hotline requirements to Chartered. Chartered has six hotline representatives answering questions and making the necessary referrals. However, the hotline only operates Monday through Friday between 8:00 a.m. and 6:00 p.m. and is closed on weekends and holidays. When a call is placed to the toll-free number during "off hours," an automated message instructs the participants to call a toll-free nurse-advice hotline. The primary use of this particular hotline is to give a customer access to advice about emergency situations which arise when other sources of information may not be available. If callers have questions about the Alliance program during non-operating hours, the nurse-advice hotline representatives instruct the callers to call back during the Alliance normal operating hours. If a caller makes a call on Friday at 6:01 p.m. and the weekend is followed by a Monday holiday, it is possible that the caller's question would not be answered until 86 hours later.

While Chartered indicated that DOH and GSCHC agreed that the hotline would be operated in this manner, we found no written modifications to the Contract that allowed Chartered to operate the hotline less than 24/7. We believe that DOH and GSCHC violated the provisions of Title 27, DCMR § 3602.2. That provision provides: "[a] contractor shall be bound by the terms of the written contract and written contract modifications signed by the contracting officer." While the District and GSCHC may have verbally modified the Contract, the District is not receiving the value it intended to receive under the Contract.

As a test, Chartered operated the hotline on two weekends in February of 2002 and on President's Day to determine the volume of weekend/holiday telephone calls. The hotline received 37 calls during the 4 weekend days of the test and 58 calls on the Monday holiday. While some may consider these numbers to be low-volume, DOH, under its oversight role, should weigh the cost to operate the hotline against the goals of the Alliance program. Until such time as DOH modifies the Contract to allow something less than a 24/7 hotline, the contractor is bound under Title 27, DCMR § 3602.2. In its role as contract administrator and

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overseer, HCSNA should ensure that GSCHC operates the dedicated hotline on the required 24/7 basis or else take steps to modify the contract in writing. If the Contract is modified to a less than 24/7 basis, the Contract price should be adjusted to reflect the reduced service level.

RECOMMENDATION 1

We recommended that the Director of DOH ensure that total contract oversight is provided by positions created within HCSNA and that those positions are promptly filled with the most qualified applicants.

DOH Response

To date, 6 to 8 of the 14 oversight positions have been filled and DOH is moving to hire the remaining positions.

OIG Comment

While the DOH response is unclear on the exact number of HCSNA positions remaining vacant (6 or 8), they have taken the recommended action to create and fill oversight positions. We consider their actions to be responsive to our recommendation and request an estimated completion date for the hiring of qualified individuals for these positions.

RECOMMENDATION 2

We recommended that the Director of DOH collect any overpayment for travel or travel expenses paid to William M. Mercer, Inc., which exceeds the maximum contract amount. In addition, ensure that any amounts billed, but not yet paid, for travel exceeding the contract maximum are rejected.

DOH Response

The DOH did not agree with this recommendation. While the reimbursement requests associated with travel were in excess of the $50,000 estimate, they were consistent with the scope of work requested by the HCSNA and provided by the Contractor. The estimated labor requirement and associated travel were underestimated at the beginning of the contract. A table showing contractor travel and other expenses was attached showing in excess of $86,000 for the first three months of the contract.

OIG Comment

In the William M. Mercer, Inc. contract (DCFRA#01-C-005), travel and expenses are clearly limited to $50,000. There is no reference in the contract to travel being an estimated amount.

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The contract line item is travel expenses - $50,000. In fact, we confirmed that the $50,000 is a fixed amount with officials at the Office of Contracting and Procurement. Further, Article IV of the Contract states "Approval of expenses must be made by the Authority's COTR [Contracting Officer's Technical Representative] or the Contracting Officer prior to incurring the expense." During our review, the DOH could produce no such approvals. We request that DOH reconsider its position and provide a response to this final report.

RECOMMENDATION 3

We recommended that the Director of DOH review the billed hours for September 2001 for the William M. Mercer, Inc. contract and recover any payments for on-site work which cannot be proven.

DOH Response

The DOH did not agree with this recommendation. Our records show no instances of payments for work that was not provided or was unauthorized.

OIG Comment

The DOH response appears to repeat the position William M. Mercer, Inc. has taken on this issue, that if the contractor asks for reimbursement, it should be made. The DOH response does not appear to be an independent assessment of facts. Again, at the time of our review, we could not verify from documentation on file at DOH that the consultant's billable hours for the on-site monitoring effort was $185,000. The point is not whether the contractor is doing a good job and whether DOH is happy with William M. Mercer's work. The point is that DOH is not effectively monitoring these expenditures because invoices submitted by the contractor do not reconcile to the expense ledger.

We ask again, that DOH review the billed hours for the contractor in question and provide either a reconciled analysis of the $185,000 payment or recover any payments that were made in error.

RECOMMENDATION 4

We recommended that the Director of DOH review and adjust the expected service levels shown in the Contract to reflect more realistic expectations based on actual service levels collected to date.

DOH Response

DOH disagrees with the audit conclusion because the original patient estimate was based on less-than-reliable statistics developed by the PBC. However, DOH acknowledges that initial

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utilization was less than projected and new figures now exist. These new figures will be verified by an independent reconciliation audit which is currently in progress.

OIG Comment

The DOH response states that the HCSNA acknowledges that utilization was less than projected. This, in fact, is what our report states. The estimated annual patient workload section of our report clearly is a discussion of how the expected workload volume estimates were determined by the contracting officials for the purpose of determining a cost for the Contract. We continue to believe that this overestimate of service levels is, as the report says, a cause for "the possible overestimation of annual contracting funding."

However, we consider the actions by DOH, as outlined in their response to meet the intent of our recommendation. We request that DOH provide us with a date for completion of the independent audit of the utilization rates, and that a copy of the independent report be forwarded to us upon completion.

RECOMMENDATION 5

We recommended that the Director of DOH calculate the exact funding surplus, reduce the contract funding by that amount, and put the funds to better use within the Department.

DOH Response

A reconciliation is currently underway to determine the year-end balance. We project an October 2002 completion date for this process.

OIG Comment

The actions taken by DOH, as outlined in the response and which are scheduled for completion by 10/31/02, clearly meet the intent our recommendation. No further action is necessary for this recommendation.

RECOMMENDATION 6

We recommended that the Director of DOH require the contractor to comply with the contract provision to operate a 24/7 hotline to answer questions concerning the Alliance program or change the Contract to a reduced service level with appropriate adjustment to contract price to reflect reduced service requirements.

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DOH Response

In July 2002, the Alliance made changes that would allow the existing nurse-advice line to also handle Alliance enrollment, eligibility, and other calls as required by the Contract.

OIG Comment

The actions taken by DOH, as outlined in the response, is considered adequate and meets the intent of our recommendation. However, we feel that the 24-hour hotline should be tested by the HCSNA on a periodic basis to assure its reliability. No further action is necessary for this recommendation.

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FINDING 2: ALLIANCE ENROLLMENT SCREENING PROCESS

SYNOPSIS

Alliance enrollees were not properly screened for program eligibility before the Alliance granted admission to the program. In fact, the Alliance rolls currently contain individuals that: (1) have unverified addresses and incomes; (2) may qualify for third-party insurance; (3) have third-party insurance; (4) are using invalid Social Security numbers or using Social Security numbers that belong to deceased individuals; and (5) have incomes exceeding the income membership requirements. The lack of proper screening occurred because the subcontractor charged with executing the enrollment process had not established adequate procedures to verify enrollment information and did not always follow existing procedures. Additionally, DOH provided little oversight to enforce enrollment contract provisions. As a result, the Alliance incurred approximately $289,000 in medical charges for individuals having third-party insurance coverage and possibly incurred charges for individuals who are not District residents and do not satisfy the income requirements.

DISCUSSION

Enrollment Process Background

The Contract's Exhibit A, Statement of Work, Section 5.1 requires GSCHC to enroll "eligible" individuals in the Alliance program. Individuals are eligible if they: (1) are District residents; (2) lack third-party insurance; and (3) have family income equal to or below 200 percent of the federal poverty level. Contract, Exhibit A, § 5.1. In addition, Section 5.5.1 provides that GSCHC shall screen each individual attempting to enroll in the Alliance for Medicaid eligibility and, if determined to be eligible, refer the individual to IMA for Medicaid enrollment. *Id.* § 5.5.1. Once an individual is determined eligible for the program, Section 5.1.4 provides that eligibility will be continuous and ongoing unless the individual: (1) gains insurance coverage; (2) changes permanent residence to a non-District address; (3) fails to provide any verification documents requested within a required time frame; or (4) earns an income above 200 percent of the federal poverty level. *Id.* § 5.1.4.

The enrollment function has been subcontracted to Chartered. At the time of our review, Chartered had enrollment specialists placed at their primary enrollment sites around the District. The primary sites include Greater Southeast Community Hospital, D.C. General Hospital, the six outpatient clinics run by the Alliance, and two other locations. Secondary sites are located at various other locations around the District where eligible individuals may be found. For example, secondary sites are located at organizations such as "So Others Might Eat" and "Bread for the City Free Clinic." The difference between a primary and secondary site is that enrollment specialists are placed at primary sites, which gives those

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sites the ability to enroll individuals instantaneously, whereas secondary sites must forward application information to Chartered for processing. Chartered also attempts to enroll individuals at street events and outreach activities as well as by taking applications through the mail.

The actual enrollment process at a primary enrollment site, in many cases, begins when individuals present themselves for medical treatment. Patient registration personnel at the health-care facility will determine if the person has any type of insurance. Individuals without insurance coverage are referred to the Chartered enrollment specialist at the facility. During that interview, a series of questions are asked to determine if the applicant is eligible for the Alliance program. Alliance eligible individuals are asked to complete an application for Alliance membership. In addition to basic information such as name, address, phone number, Social Security number, employer name and household members, the program application form requires the potential enrollee to affirm by signature that neither the enrollee nor any family member listed on the application has any source of health insurance. The application also provides space for the enrollment specialist to record the type of proof provided for program residency and income requirements and requires the signature of the specialist that he/she verified that information.

If, in the opinion of the enrollment specialist, adequate proof of program eligibility has been presented at the time of the interview and the application is completed satisfactorily, the applicant is immediately enrolled in the Alliance program for a period of 6 months. The application information is entered into the Managed Health Care computer system, which tracks enrollment and other information, and the computer assigns a member number that is affixed to the application form. A membership card is mailed to the new member within 10 days.

However, if enrollment criteria are not satisfactorily proven at the time of the interview, the applicant will be placed on the Alliance rolls in what is called a "presumptive status." This status gives the enrollee 30 days to return to the enrollment specialist with adequate proof of eligibility. The information is entered into the computer as described, except presumptive members do not receive a membership card until their status is changed. If a presumptive member does not present eligibility proof within the 30-day window, Chartered will remove that member from the rolls.

Review of Enrollment Process

We performed reviews on three segments of the enrollment process, including a review of enrollment documentation, third-party insurance coverage, and a review of enrollee Social Security numbers.

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Unverified Addresses and Incomes - In order to ensure that Chartered was only accepting individuals in the Alliance system who conformed to established guidelines for residency and income, we randomly selected 80 Alliance members and reviewed documentation used to make enrollment decisions. Our attempts to locate the documents in question became futile because of the poor filing system. We then turned the search over to Chartered personnel, who also had difficulty locating the documentation and ultimately only found documentation for 72 or 90 percent of the requested members. The process of retrieving and assembling this documentation took Chartered personnel in excess of 3 weeks because the files were so disorganized. The results of our random sample review are summarized below.

Table 3. Analysis of Enrollment Documentation

	Number	Files Found	Percent*
Number Complete	25	72	35
No Proof of Address	44	72	61
No Proof of Income	30	72	42
Not Signed by Specialist	8	72	11

* Percent calculated by dividing the Number by the Files Found.

As shown, enrollment specialists were able to accurately complete the Alliance application only 35 percent of the time for the sampled applications. The types of errors found are attributed to enrollment specialists not following procedures, not thoroughly reviewing information supplied, and exercising poor judgment when analyzing applications. For example, we found one application for which a New Jersey driver's license was accepted as proof of District residence and another application for which the applicant submitted proof of income in the amount of $19,559, which is $2,379 above the $17,180 maximum limit for Alliance eligibility for a single individual. In both cases the applicants were approved. The majority of sampled applications simply did not contain the assurance used by reviewers to admit individuals into the program and therefore are questionable. Because of the enrollment errors, the Alliance possibly incurred medical charges for individuals who do not meet the residency and income requirements.

The enrollment errors can also be attributed to DOH providing little oversight to enforce enrollment contract provisions. GSCHC should ensure that enrollment specialists thoroughly understand the screening process and receive refresher training at least once a year. In addition, the current member files should be re-screened to ensure that those currently enrolled actually are eligible under contract guidelines.

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Third-Party Insurance Coverage - In addition to the residency and income requirements, an Alliance member cannot have third-party insurance coverage. The Contract also requires the screening of all Alliance applicants for Medicaid eligibility. Any applicant thought by the enrollment specialist to be eligible for Medicaid coverage must be referred to IMA. IMA is a division of the Department of Human Services (DHS) and has responsibility for the actual determination of eligibility.

When Chartered's enrollment specialists enroll members in the Alliance program, they ask the members if they have third-party insurance. The enrollment specialists must rely on the members' responses since they can not verify the information. However, it is possible to determine if an applicant has Medicaid coverage or other third-party insurance, because the Medical Assistance Administration (MAA), which is a division of DOH, has the capability to make that determination. In March 2002, Chartered informed us that there had only been one MAA check conducted to determine if the Alliance members had third-party insurance. Chartered officials stated Chartered sent the MAA a database of the Alliance members in January 2002 for Medicaid coverage screening. The officials also stated the database contained 21,318 Alliance members and represented over 8 months of enrollment activity. MAA found that 1,382 Alliance members (about 6.5 percent of the 21,318 members) were enrolled in the Medicaid program. We determined about 15 percent of those members (202 individuals) had in fact incurred some type of medical treatment for which a claim to Alliance was generated. We also determined that those claims were in excess of $289,000, which can be recouped by the health-care providers. GSCHC should take steps to recover this money and return the collected funds to the District.

Also, during the period since the original MAA Medicaid verification check in January and the middle of April when our review of this area ceased, the Alliance rolls continued to grow. A HCSNA representative informed us that MAA had not performed another review of the Alliance rolls as of mid-April 2002. As a result, it is unknown how many of these additional members were covered by Medicaid and if any member with Medicaid coverage has filed a claim with the Alliance. HCSNA should take steps to recover monies paid to the health-care providers for the members with Medicaid coverage and ensure that GSCHC establishes a system to have the Medicaid status of all new applicants reviewed before admittance to the Alliance program is granted.

We also spoke with IMA personnel to determine if enrollment specialists are referring applicants who appear to be Medicaid eligible. An IMA official stated there is no formal agreement with DHS for IMA to determine Medicaid eligibility, but there are two IMA employees currently located at the D.C. General Hospital. The IMA representative also stated there has been an IMA presence at that location in excess of 10 years. IMA personnel at D.C. General Hospital told us that they receive no referrals by Alliance enrollment specialists. Time constraints precluded us from interviewing every enrollment specialist and from verifying the actual number of referrals, if any, to IMA. It is possible that IMA offices other than those at D.C. General Hospital received referrals. However, neither GSCHC nor

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HCSNA ensures that this referral is always made. It is important that anyone eligible for Medicaid be enrolled in the Medicaid program in order to minimize Alliance program cost. Also, it is reasonable to expect GSCHC to comply with the Contract. GSCHC and the HCSNA should both take steps to ensure compliance with this portion of the Contract.

Invalid Social Security Numbers - As an additional check of the enrollment process, we had the Social Security numbers of the 26,606 Alliance members enrolled as of April 16, 2002, reviewed by a Social Security number validation service. Based on our review, it appears that 2,632 (10 percent) of the Social Security numbers used by Alliance enrollees are invalid, and an additional 724 are in some way questionable. The results of that review follow:

Table 4. Review of Social Security Numbers

Presumed Valid Social Security Numbers (SSN)	
23,250	SSNs appear to be valid numbers
Questionable SSNs	
720	SSNs may not have been assigned
4	SSNs out of range / possible recent assignment
Presumed Invalid SSNs	
1495	SSNs cannot start with a 9
582	Too few, or illegal character(s) in SSNs
293	First three digits of SSN not issued
157	SSNs belonged to a person reported deceased
101	SSNs reported as out of range and never assigned
3	Middle two digits of SSN cannot both be zeros
1	Last four digits of SSN cannot be all zeros

We did attempt to validate the 157 Social Security numbers reported as belonging to a deceased person. Through a search of the Social Security death index, we determined that 39 were actual Alliance members that had died but were still being carried on the Alliance rolls. We were unable to locate any information on 9 individuals, and thus, 109 applicants appeared to be using the invalid numbers. A request for the Alliance applications for each of the 109 individuals was made to Chartered. Chartered was only able to locate 79 of the requested 109 applications, while 30 of the applications remained in the "missing" category.

Our review of those applications showed that 38 were entered incorrectly into the Alliance computers and were not the Social Security numbers used by the applicant. One application did not contain a Social Security number, and it is unknown how or why a number was

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entered for that applicant. However, 40 Social Security numbers were entered into the Alliance computers as shown on the application. Those 40 numbers appear to belong to someone who is deceased. The status of the 30 missing applications should be determined and could cause the number of improperly used Social Security numbers to increase. Information on this improper use of Social Security numbers has been forwarded to the OIG Assistant Inspector General for Investigations.

Incomes Exceeding Income Membership Requirements - Finally, we attempted to match the 26,606 Alliance members' Social Security numbers with tax year 2001 tax returns to ensure that Alliance members complied with the maximum income requirements as shown in the Income Eligibility Scale in the Background section of the report. The District's Office of Tax and Revenue (OTR) matched the Social Security numbers with the tax returns and found that only 7,594 of the above individuals filed a tax return during 2001. However, of those that did file, 436 exceeded the gross income levels for Alliance membership (see schedule below).

Table 5. Schedule of Alliance Enrollees with Incomes Exceeding Program Limits in Tax Year 2001

Total Exemptions	Alliance Gross Income Requirements (Below)	Number Exceeding Gross Income Requirement
1	$17,180	164
2	$23,220	160
3	$29,260	61
4	$35,300	42
5	$41,340	8
6	$47,380	1
7	$53,420	0
8	$59,460	0
Total		**436**

Although over 18,000 of the Alliance members did not file District tax returns, D.C. and federal tax laws recognize that individuals earning less than a certain level of income are not required to file. However, there is a possibility that many of the non-filers may live outside the District and, therefore, would not submit a return. Time constraints precluded us from a further review of Alliance members who did not file a District tax return. Chartered should require a tax return as proof of income and residency from any Alliance applicant required to file a tax return.

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RECOMMENDATION 7

We recommended that the Director of DOH require GSCHC to train and ensure that Alliance enrollment specialists understand screening procedures and are, in fact, following those procedures when performing the enrollment service. Also, ensure that GSCHC is re-screening members at the required 6-month intervals to determine whether they remain eligible.

DOH Response

DOH stated that they plan to complete a compliance analysis of contract terms, industry standards, etc. for future contract terms by October 25, 2002. Included will be development of training polices and procedures.

OIG Comment

The actions taken by DOH, as outlined in the response, clearly meets the intent of our recommendation. No further action is needed for this recommendation.

RECOMMENDATION 8

We recommended that the Director of DOH ensure that GSCHC establishes procedures to determine the Medicaid status of all applicants before admittance to the Alliance program is granted. In addition, recover all payments made by the Alliance for patients covered by the Medicaid program at the time health-care service was rendered and remit recovered funds to the District.

DOH Response

DOH stated that the HCNSA, Medicaid, IMA, and the Alliance are reviewing this issue to formulate a method to check Medicaid status prior to a determination of benefits. This will result in a contract modification and an amendment to application regulations.

OIG Comment

The actions taken by DOH, as outlined in the response, clearly meets the intent of our recommendation. We request that DOH provide a target date for the contract modification.

RECOMMENDATION 9

We recommended that the Director of DOH ensure that GSCHC determines that applicants for Alliance membership are not eligible for Medicaid coverage before Alliance eligibility is declared.

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DOH Response

DOH is considering appropriate modifications to the Contract to require verification of Medicaid status prior to determination of Alliance eligibility.

OIG Comment

The response meets the intent of our recommendations. We request that a target date for the contract modification be provided to us.

RECOMMENDATION 10

We recommended that the Director of DOH require GSCHC to use a tax return, for those Alliance applicants who are required to file one, as proof of income and residence for Alliance insurance.

DOH Response

DOH disagrees with our recommendation stating it would be too time consuming and cumbersome and still may not verify income accurately. DOH will have an independent review of this problem and offer recommendations.

OIG Comment

While DOH did not agree with the recommendation, DOH did propose that an alternative method to verify income be explored under the auspice of an administrative services audit. We feel that the intent of our recommendation has been addressed by this action. We request that a target date be forwarded to use and, upon completion of the administrative services audit, a copy of the results be made available to us. We also recommend that DOH coordinate with OTR to determine if the 436 individuals identified did, in fact, exceed income levels, and take appropriate corrective action.

RECOMMENDATION 11

We recommended that the Director of DOH review, periodically, Alliance membership rolls and ensure that enrollees meet all membership requirements. Random sampling techniques may be employed.

DOH Response

DOH will examine membership rolls and verify membership requirements are met. In addition, we will modify the auditor's contract to verify requirements. HCSNA may also perform random sampling.

FINDINGS AND RECOMMENDATIONS

OIG Comment

The DOH response meets the intent of our recommendation. We request a target date for the modification to the audit contract.

EXHIBIT A

OTHER MATTERS OF INTEREST

TRAUMA SERVICES

The Contract's Exhibit A, Statement of Work, Section 4.3.4) provides: "[t]he Contractor shall be responsible for ensuring the provision of trauma services to enrolled Eligible Uninsureds consistent with the trauma services that were provided at D.C. General [Hospital] during the twelve (12) month period immediately preceding the date this Agreement is executed ('Comparable Trauma Services'). Contract, Exhibit A § 4.3.4. Section 4.3.5 provides that the:

> "[c]ontractor shall initiate Comparable Trauma Services at Greater Southeast Community Hospital no later than August 31, 2001, and maintain such Comparable Trauma Services for the duration of the agreement; provided, however, that if Contractor is unable to initiate such Comparable Trauma Services at Greater Southeast Community Hospital [no later than] August 31, 2001, Contractor shall ensure the availability of such services through agreements with other providers within the District of Columbia."

Id. § 4.3.5.

Trauma Center Certification. ACS is the organization which certifies trauma centers. ACS certifies a trauma center as a Level I, II, III, or IV with Level I being the highest level of certification awarded. To receive an ACS certification, the hospital emergency room must meet requirements specified in the ACS booklet entitled "Resources for Optimal Care of the Injured Patient: 1999." Each level of certification requires the availability of differing degrees of clinical capabilities, medical facilities, types of professional staffing, etc.

Contractor Compliance. GSCHC is in compliance with the Contract requirement for trauma services. Contrary to belief, during the 12 month period immediately preceding the execution date of the Contract, D.C. General Hospital's trauma center was not certified as Level I. The D.C. General Hospital's trauma center has not been certified as Level I since 1996. ACS issued a Level I certification to D.C. General Hospital in 1993, but that certification expired in 1996 (a hospital must be re-certified every 3 years). No re-certification was performed until 1999, at which time, the hospital did not receive a Level I certification inspection.

Since D.C. General Hospital was not providing Level I trauma services, GSCHC was not obligated to provide such services at the Greater Southeast Community Hospital, or arrange for such services at other hospitals, by August 31, 2001. GSCHC has, however, provided Level I trauma care since the beginning of the Contract at two District locations: George Washington University Hospital and Children's National Medical Center. The GSCHC recently added Howard University Hospital as a third location providing Level 1 trauma services.

EXHIBIT A

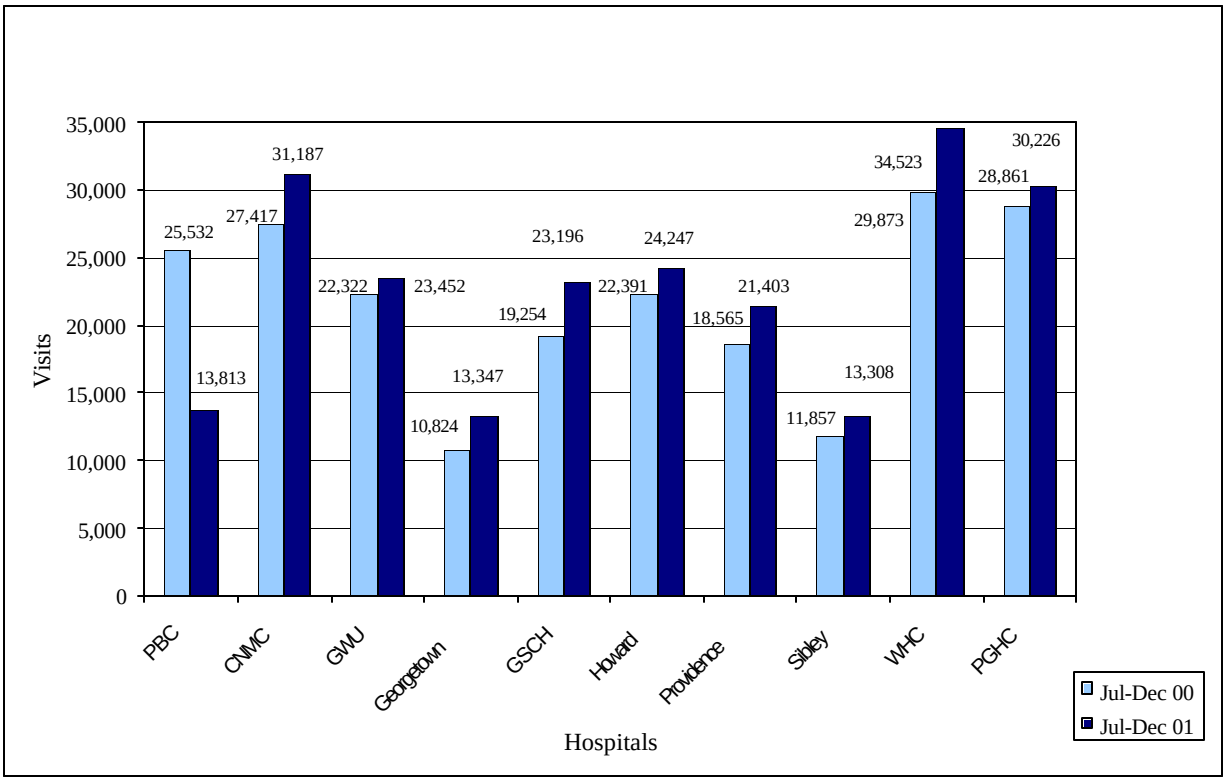
OTHER MATTERS OF INTEREST

EMERGENCY ROOM VISITS

We analyzed the emergency room visits for the current eight acute care hospitals within the District, the D.C. General Hospital, and PGHC in Maryland to determine whether the number of patients seen by each had increased since the closure of D.C. General Hospital. PGHC was included because it is located just over the District line, and District residents are known to use their resources. We compared the 6-month period of July through December 2000, a period during which the D.C. General Hospital was in operation, with the same 6-month period in 2001 after its closure.

The chart below shows the results of our review. There was an increased workload at every hospital emergency room surveyed after the closure of D.C. General Hospital. We noted that the number of visitors to the 10 emergency rooms during the 6-month survey period in 2000 was 216,824. The same period in 2001 showed that patient workloads had increased by 11,806 (5 percent).

Chart 1. Emergency Room Visits



CNMC-Children's National Medical Center, **GWU**-George Washington University Hospital, **Georgetown**-Georgetown University Hospital, **GSCH**-Greater Southeast Community Hospital, **Howard**-Howard University Hospital, **Providence**-Providence Hospital, **Sibley**-Sibley Memorial Hospital, **WHC**-Washington Hospital Center, **PGHC**-Prince George's Hospital Center.

EXHIBIT A

OTHER MATTERS OF INTEREST

The increase in the District's emergency room visits is consistent with the national trend. Recent reports by the American Hospital Association, the D.C. Hospital Association and the National Center of Health Statistics indicate that emergency room visits are on the increase across the United States. The General Accounting Office, in a June 2001 report entitled "Emergency Care: EMTALA Implementation and Enforcement," gives several reasons for the increases. The report credits several factors, including the difficulty of some managed care patients to obtain timely appointments with their doctors. However, along with the additional percent workload increase experienced over the surveyed period, it is likely that the closure of D.C. General Hospital was a contributing factor for the rise in emergency room visits among the hospitals we examined.

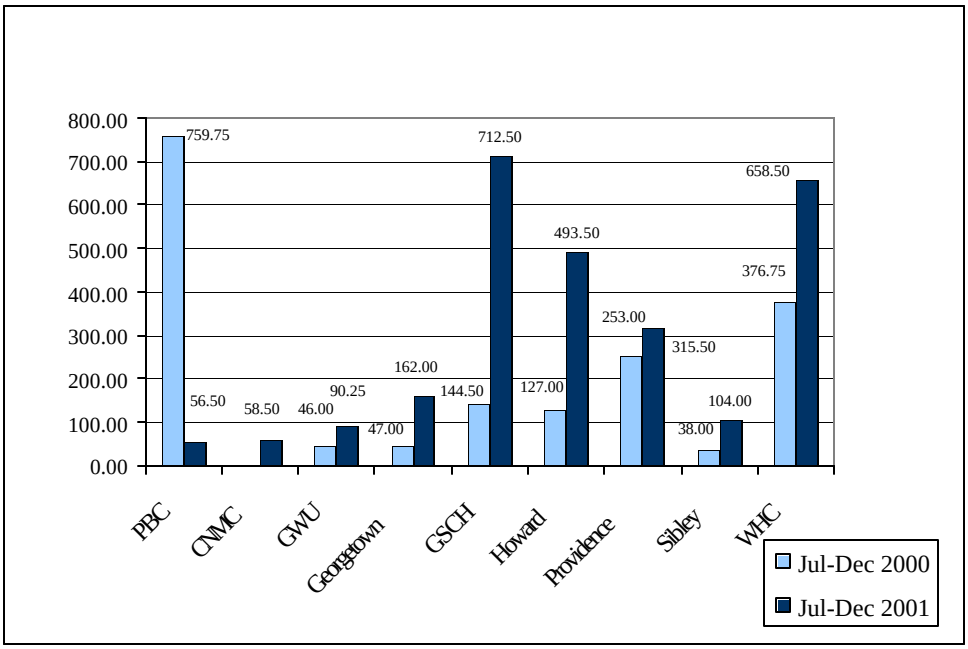
EMERGENCY ROOM CLOSURES

When analyzing emergency room closures, it is important to note two relevant factors. First, District hospitals cannot arbitrarily close emergency rooms to ambulance traffic. They may make a closure request to DCFEMS, which is the organization responsible for ambulance service in the District. An approval for closure may be granted for one of the following reasons: (a) emergency department, trauma center, or operation room is at maximum capacity; (b) physical plant or equipment problems; (c) staffing shortages; (d) special events; or (e) no hospital beds are available. The second issue arises when choosing a hospital to which a patient will be transported, requiring DCFEMS to match a patient's condition to the receiving hospital's capability and operating status. For transportation purposes, an injured person will be classified as a Code I, II, or III **trauma** patient while regular medical problems are classified as Code I, II, or III **medical**. A patient's status is considered more severe if the individual is placed in the trauma category with codes ranging from the most critical (Code I) to a less critical status (Codes II and III).

We analyzed emergency room closures for the 6-month period of July through December 2000 (before closure of D.C. General Hospital) and from July through December 2001 (post-closure). In this review, we included nine hospital emergency rooms. Excluded from this review was PGHC because that facility does not use the same definition for closure as the other nine hospitals and, as such would have provided an incompatible comparison. Hospital emergency room closure statistics are summarized in the following chart.

OTHER MATTERS OF INTEREST

Chart 2. Emergency Room Closures



CNMC-Children's National Medical Center, **GWU**-George Washington University Hospital, **Georgetown**-Georgetown University Hospital, **GSCH**-Greater Southeast Community Hospital, **Howard**-Howard University Hospital, **Providence**-Providence Hospital, **Sibley**-Sibley Memorial Hospital, **WHC**-Washington Hospital Center.

The number of hours emergency rooms closed increased after the closure of D.C. General Hospital. Total closure hours, between the two periods reviewed, rose by 859 hours from 1,792 combined closures hours to 2,651 combined closure hours. This represents a 48 percent increase in the combined hours emergency rooms in the District were closed. Audit evidence is insufficient to conclude that the entire 48 percent increase was a result of the closure of D.C. General Hospital. In fact, a Trend Watch report ("Emergency Departments - An Essential Access Point to Care, March 2001, Vol. 3, No. 1) issued by the American Hospital Association suggests that emergency room closures are increasing all over the United States. However, we suspect that a portion of the local closures resulted from former D.C. General Hospital patients going to other hospitals for treatment. Audit evidence is insufficient to conclude that adverse situations occurred as a result of the increase in emergency room closures.

AVERAGE DCFEMS PATIENT PREPARATION AND TRANSPORT TIME

A DCFEMS official informed us that the response time, patient preparation time, and the transport time is recorded when an individual is taken to a hospital using DCFEMS

equipment. The official defined response time, preparation time, and transport time as follows:

- Response time is the elapsed time it takes the ambulance to get to the scene after the call is received.
- Patient preparation time is defined as the time between the arrival of the ambulance and when the patient is ready for transport to a hospital.
- Transport time is the elapsed time it takes for the ambulance to leave the scene to the time the ambulance arrives at the hospital.

We compared the patient preparation and transport times of patients using DCFEMS vehicles before the closure of D.C. General Hospital with the preparation and transport times after the closure of D.C. General Hospital. To do that, we compared the months of July through December 2000 with the same months in 2001. We found that average preparation and transport time had in fact increased by 5 minutes 12 seconds, on average, for the periods compared. The following chart shows the actual comparisons using times reported by DCFEMS.

Table 6. Patient Preparation and Transport Times (in Minutes)

Month	2000	2001	Difference
July	24:53	30:48	+ 05:55
August	25:22	31:22	+ 06:00
September	24:53	29:18	+ 04:25
October	24:57	29:27	+ 04:30
November	25:33	30:42	+ 05:09
December	25:38	30:50	+ 05:12
Average Time			**+ 05:12**

We did not verify the transport times reported to us by DCFEMS, and we do not represent them in this schedule as being audited figures. While the unaudited data suggest that transport times have increased since the closure of D.C. General Hospital, audit evidence is insufficient to draw conclusions as to whether the closure is largely responsible for the longer transport times. In fact, the emergency room at D.C. General Hospital remains open even though in-patients are no longer accepted. In addition, several factors such as patients' condition, capability of hospitals, status of emergency rooms, as well as the distance of the hospital from the patient can impact transportation time. However, it is not unreasonable to suspect that closure of D.C. General Hospital, to some extent, affected transportation time.

EXHIBIT B

SUMMARY OF POTENTIAL BENEFITS RESULTING FROM AUDIT

Recommendation	Description of Benefit	Amount and/or Type of Monetary Benefit
1	Compliance and Internal Control Improve Oversight of the Contract.	Nonmonetary
2	Economy and Efficiency Collect overpayment for travel expenses in excess of contract requirements.	Monetary Approximately $194,597
3	Economy and Efficiency Collect overpayment for excess hours billed.	Monetary As much as $100,000
4	Economy and Efficiency Results in adjustment of contract value based on actual service levels.	Monetary See Recommendation 5 Benefit
5	Economy and Efficiency Results in recalculation of contract value to identify funding surplus.	Monetary As much as $10 million could be put to better use
6	Compliance and Internal Control Enforce compliance with contract's 24/7 hotline requirement or amend contract.	Nonmonetary
7	Compliance and Internal Control Improve enrollment procedures.	Nonmonetary
8	Compliance and Internal Control Economy and Efficiency Establish procedures for determining Medicaid eligibility. Recover expenses paid for Medicaid covered patients.	Monetary At least $289,000
9	Compliance and Internal Control Improve oversight of contractor's Medicaid screening.	Nonmonetary
10	Compliance and Internal Control Improve membership enrollment process.	Nonmonetary

EXHIBIT B

SUMMARY OF POTENTIAL BENEFITS RESULTING FROM AUDIT

Recommendation	Description of Benefit	Amount and/or Type of Monetary Benefit
11	Compliance and Internal Control Ensure integrity of membership rolls.	Nonmonetary

EXHIBIT C

MANAGEMENT RESPONSE FROM THE DEPARTMENT OF HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Office of the Director

September 30, 2002

Charles C. Maddox, Esq.
Inspector General
Office of the Inspector General
717 14th Street, N.W.
Washington, D.C. 20005

Dear Mr. Maddox:

Enclosed is the Department of Health's response to your draft report summarizing the results of the audit of the Health Care Safety Contract (OIG No. 02-1-2HC).

The contract with Greater Southeast Community Hospital Corporation (GSCHC) provides health care services to the most vulnerable within our population. As the oversight and monitoring body for this contract, the Health Care Safety Net Administration (HCSNA) welcomes a fair and accurate assessment of it's oversight capabilities. During the months in which you collected data for this audit, the HCSNA provided numerous documents and information to assist you in forming the basis for your report. We believe that due to the resignation of one your auditors, much of the information was not included in your draft report. We trust that the information included in this report will correct all associated deficiencies.

Thank you again for the opportunity to respond to your draft report on the HCSNA. If you have any questions, please free to contact me at (202) 442-5999 or Brenda L. Thompson, Deputy Director, HCSNA at (202) 442-9220.

Sincerely,

James A. Buford
Acting Director

Enclosures

EXHIBIT C

MANAGEMENT RESPONSE FROM THE DEPARTMENT OF HEALTH

cc: The Honorable Anthony Williams, Mayor *(without enclosures)*
John A. Koskinen, City Administrator
Carolyn Graham, Deputy Mayor for Children, Youth, Family & Elders
Councilmember Linda Cropp, Chairman, City Council *(without enclosures)*
Councilmember Sandra Allen, Chairman, Committee on Human Services *(without enclosures)*
Councilmember Vincent Orange, Chairman, Committee on Government Operations *(without enclosures)*
Councilmember David Catania *(without enclosures)*
Brenda L. Thompson, Deputy Director, HCSNA
Ana Raley, Chairman & President, GSCHC
Glendia Hatton, President, D.C. Chartered Health Plan, Inc.

825 North Capitol Street, N.E., Washington, D.C. 20002 (202) 442-5999 Fax (202) 442-4788

EXHIBIT C

MANAGEMENT RESPONSE FROM THE DEPARTMENT OF HEALTH

RESPONSE TO INSPECTOR GENERAL'S REPORT ON HCSNA CONTRACT (OIG NO. 02-1-2HC)

OIG- RECOMMENDATIONS

1. **Ensure that total contract oversight is provided by positions created within HCSNA and that those positions are promptly filled with the most qualified applicants.**

   HCSNA Response:

   The HCSNA has established a core team to support the Administration's oversight functions.

   The current Deputy Director was appointed in December 2001. To date, six of the fourteen available positions are filled. The DC Office of Personnel is currently processing four of the six vacant positions. We expect recruitment to begin within the month. The four positions include the Systems Manager and Operations Manager (two lead positions), the reporting analyst and medical records technician. The two remaining positions were recently added to the HCSNA. Position descriptions have not been developed and funding is uncertain.

   Despite hiring issues, the HCSNA developed the capacity to focus on short-term priorities while beginning the longer-term process of fully developing an effective oversight and management system to carry out its oversight responsibilities with the assistance of Mercer, its contractor.

   Attached is a copy of the developed position descriptions for the HCSNA (Appendix 1) and the HCSNA Table of Organization and staffing plan (Appendix 2).

2. **Collect any overpayment for travel or travel expenses paid to William H. Mercer, Inc., which exceeds the maximum contract amount. In addition, ensure that any amounts billed, but not yet paid, for travel exceeding the contract maximum is rejected.**

   HCSNA Response: A review of the reimbursement requests associated with travel, while in excess of the $50,000 estimate, were consistent with the scope of work requested by HCSNA and provided by the contractor. Clearly, the estimated labor requirement and associated travel were underestimated at the beginning of the contract and the search for qualified and experienced individuals to staff the HCSNA proved to be an unexpected challenge.

   The contractor has provided technical assistance, often in the capacity of "staff," during the course of their contract. A further review of invoices indicates that the

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MANAGEMENT RESPONSE FROM THE DEPARTMENT OF HEALTH

$50,000 travel/expense estimate was exceeded during the first three months of the contract ($96,000): during perhaps the most critical period of the program – the start-up phase.

Attached is a copy of a contractor invoice for the month of April 2002 (Appendix 3). The purpose of the table below is to summarize the relationship between the scope of work, man-hours, travel and expenses, non-travel expenses and associated costs.

Expenses for Mercer Contract

Months	Travel	Other Expenses	Travel & Other Expenses	Personnel Services	Total
May-02	$ 7,489.28	$ 3,572.25		$ 150,663.50	$ 161,725.03
Apr-02	$ 9,609.87	$ 328.15		$ 135,195.00	$ 145,133.02
Mar-02	$ 8,614.17	$ 5,679.56		$ 165,283.30	$ 179,577.03
Feb-02	$ 9,872.38	$ 4,177.13		$ 214,145.00	$ 228,194.51
Jan-02	$ 13,275.46	$ 2,616.68		$ 127,443.00	$ 143,335.14
Dec-01			$ 16,378.00	$ 103,261.75	$ 119,639.75
Nov-01			$ 20,473.00	$ 137,159.50	$ 157,632.50
Oct-01			$ 25,068.32	$ 195,450.50	$ 220,518.82
Sep-01			$ 35,067.71	$ 499,138.00	$ 534,205.71
Aug-01			$ 21,825.21	$ 354,331.65	$ 376,156.86
Jul-01			$ 39,681.90	$ 276,902.50	$ 316,584.40
Jun-01			$ 45,011.56	$ 204,032.00	$ 249,043.56
May-01			$ 1,437.14	$ 170,195.25	$ 171,632.39
Total	$ 48,861.16	$ 16,373.77	$ 204,942.84	$ 2,733,200.95	$ 3,003,378.72

-- Please note that the data is by contract year and not fiscal year.
-- The contract with Mercer is by Fiscal Year.

3. Review the billed hours for September 2001 for the William H. Mercer, Inc. contract and recover any payments for on-site work, which cannot be proven.

HCSNA Response: DOH supports the considerable contribution of the Mercer Group in providing technical assistance to the HCSNA project. Our records show no instances of payments for on-site work or off-site work that was not provided or unauthorized. Instead, we note that Mercer's project assistance has been flexible in working with DOH to provide support and activities beyond their initial contract and to redirect resources as required by DOH.

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Between June and September 2001, Mercer provided 7.4 FTEs. This was the staffing required to support the project across all tasks—all of which relate either directly or indirectly to the contract monitoring function (not only task 4 which is the focus of the Inspector General's concern in his draft report.).

In September 2001, Mercer provided 12.9 FTEs to monitor contract performance (Appendix 4). Activities that supported such monitoring functions included developing databases, information systems, and clinical and financial protocols, as well as analyzing reports and assisting in day-to-day program operations. Given the pressing issues relevant to the HCSNA, contract flexibility on the part of Mercer helped DOH meet its various challenges associated with project start-up.

4. **Review and adjust the expected service levels shown in the Contract to reflect more realistic expectations based on actual service levels collected to date.**

HCSNA Response: After careful review of this recommendation and more recent data not considered by the Inspector General, the HCSNA respectfully disagrees with the conclusions that service levels are inflated and that surplus funding exists.

In his draft report based on preliminary data for a new program, the Inspector General opined that the demand for Alliance services was unrealistically inflated and that lead to "the possible overestimation of annual contract funding" as shown in the reconciliation audit for the first six months of the Alliance program.

The service levels as stated in the Contract were based on the experience of the Public Benefit Corporation (including D.C. General Hospital) and its less-than-reliable statistics. To avoid a shortage of services during the transition to the Alliance program, the Contract initially stated service levels approximately 30% above projected baseline volumes.

The HCSNA acknowledges that initial utilization for the Alliance program was less than projected, thus giving rise to idea that the contract levels were inflated. However, periodic monitoring by the HCSNA shows utilization increased in all service categories during the final six months of the First Contract Year ending May 31, 2002 and have continued to increase in all service categories during the Second Contract Year starting June 1, 2002. The increased utilization, which was not considered by the Inspector General, will be verified by the independent reconciliation audit currently in progress for the First Contract Year.

5. **Calculate the exact funding surplus, reduce the contract funding by that amount, and put the funds to better use within the Department.**

HCSNA Response: Calculating the funding surplus for the first contract year is an "end-of-year" process. The reconciliation is currently underway to determine the year-end balance; we project an October completion of this process. The

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recommendation to determine the exact funding surplus and to reduce contract funding after taking a "snapshot" of the first six months of the contract would have been very premature and ill advised.

The $10 million surplus referred to in the Report was based on findings resulting from the reconciliation process conducted by Gardiner-Kamya, covering the first six months of the contract year. The Gardiner-Kamya report was issued April 17, 2002.

The $10 million referred to in the Report was not "provided to GSCHC during the first six months of the contract." These funds remained in an account with Bank of America for future disbursements.

The initial year of the Health Care Safety Net Initiative experienced a number of contract modifications due, in large part, to the complexity of the program and the need to make operational and program adjustments. These modifications, which had financial impacts on the contract, were made available to the Inspector General staff. An analysis of these modifications would have clearly resulted in a much different conclusion regarding a projected funding surplus.

6. **Require the contractor to comply with the contract provision to operate a 24/7 hotline to answer questions concerning the Alliance program or change the Contract to a reduced service level with appropriate adjustment to contract price to reflect reduced service requirements.**

HCSNA Response: The Alliance 24/7 Nurse-Advice Line has been very successful. During the first year of the contract, the hotline provided advice and assistance to 1,053 Alliance and prospective members. As the program matures, each month there are increased calls to the hotline. The Alliance Nurse-Advice Line became operational in July 2001. In July 2002, the Alliance made changes that would allow the Nurse-Advice Line to handle medical calls, but also enrollment, eligibility and all other calls as required by the contract.

During the first three months of the contract, statistics were not tracked by month. That tracking was adjusted to capture monthly totals in April 2002 and continues today. Please note that calls are initially taken by both clinicians and non-clinicians, but once the caller identifies themselves as needing "symptomatic or illness" assistance, and a non-clinician has answered the call, the caller is immediately transferred to a clinician.

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The following is a summary of member calls made to the Alliance Nurse-Advice Line:

RN Entered Calls	Q1 (1/02-3-02)	April	May	June	Total
Symptomatic/Illness	184	62	86	155	487
Provider Referral	51	15	20	41	127
General Health Info	19	4	6	14	43
Customer Service/Benefits	60	11	22	92	185
Other	11	6	11	15	43
Grand Total:	325	98	145	317	**885**
Non-RN Entered Calls	Q1 (1/02-3-02)	April	May	June	Total
Provider Referral	4	1	3	10	18
Customer Service/Benefits	20	12	21	81	134
Other	5	4	4	3	16
Grand Total:	29	17	28	94	**168**

***"RN and Non-RN entered" means that either a clinician answered the call or a non-clinician.**
***The "Symptomatic/Illness" calls were triaged to some level of care (ie: ER).**

Grand Total All Calls RN/Non-RN	Q1 (1/02-3-02)	April	May	June	Total
	354	115	173	411	1,053

***Grand Total includes symtomatic and non-symtomatic calls**

This is an issue on the Contract Compliance Issue Report Log. The HCSNA is monitoring this issue and working with the Alliance to ensure complete compliance. The Contract states: 5.12.2 "The Contractor shall maintain and staff a twenty-four (24) hour, seven (7) day - a- week toll free dedicated hotline to respond to enrolled eligible uninsureds inquires, complaints and problems raised regarding services. The Contractor's internal eligible uninsured hotline staff is required to ask the caller whether or not they are satisfied with the response given to their call. All calls must be documented, and if the caller is referred to the appropriate individual for follow-up and/or resolution, This referral must take place within forty-eight (48) hours of the call."

Chartered Health Plan Inc. has an established hotline in its Member Services Department that addresses questions, handles complaints and provides information to Alliance members between the hours of 8 a.m. and 6 p.m. After normal business hours, the lines are transferred to a Nurse-Advice hotline to ensure coverage 24 hours a day, 7 days a week. The caller is greeted by a licensed Nurse that says, "Hello, DC HealthCare Alliance, How can I help you?" Chartered Health Plan Inc. has the same arrangement for its Medicaid line of business. The Alliance and Medicaid have similar benefit structures and the hot-line script has been mimicked to suit the Alliance membership. On the Alliance Nurse-Advice line, the nurse is capable of answering Alliance benefit questions, addressing clinical concerns, triaging care and documenting complaints. In the event that a member calls to file a complaint, the issue is documented and turned

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over to a Member Services representative the following morning. This system is seamless to the member.

7. **Require GSCHC to train and ensure that Alliance enrollment specialists understand screening procedures and are, in fact, following those procedures when performing the enrollment service. Also, ensure that GSCHC is re-screening members at the required 6-month intervals to determine whether they remain eligible.**

HCSNA Response: The Health Care Safety Net Administration has developed and conducted the Alliance Administrative Services Analysis in the form of a desk audit and onsite assessment. This analysis is limited to the priority functions of eligibility, enrollment, and claims processing. The analysis evaluates the Alliance's compliance with administrative contractual terms and compares overall performance to the usual and customary administrative processes and best practices necessary for optimal eligibility determination, member enrollment, and claims processing in an integrated, managed care setting. The HCSNA is currently completing the Administrative Analysis. We have made some preliminary findings and have conducted an exit interview with Chartered Health Plan. The exit interview summaries found in Appendix 5, contain some of the same findings as the Inspector General's report. We acknowledge that some of the enrollment errors found by the OIG are valid. The HCSNA will be developing a report, which contains the findings of the Administrative Services Assessment.

The Administrative Service Analysis is conducted via a team approach, using Health Care Safety Net Administration (HCSNA) staff with technical assistance and subject matter expertise from Mercer. The timeline for completion should require four to six weeks and will be highly dependant on timely cooperation and assistance by the Alliance. The attached Statement of Work (Appendix 6) outlines the project overview, purpose, guiding principles, and team members along with project tasks.

Pursuant to "Health Care Privatization Amendment Act of 2001", D.C. Law 14-18, the HCSNA has the role and responsibility of administering and monitoring compliance with contracts into which the Mayor enters. This oversight responsibility includes the contract with Greater Southeast Community Hospital Corporation (GSCHC). See D.C. Official Code § 7-1401. In order to achieve these efforts, the HCSNA developed a strategic planning guide that led to the prioritization of evaluation and monitoring tasks for the first contract year. For a full complement of the planned compliance activities please refer to the HCSNA draft Evaluation and Monitoring Plan (Appendix 7), along with the Strategic Plan, for 2002-2003 (Appendix 8).

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Response to Recommendations and Findings:

The following paragraphs represent a summary of some of the findings from the Administrative Services Assessment.

In general, after a review of enrollment documentation, third party insurance coverage and review of enrollee Social Security numbers, it appears that the OIG recommendations are in three (3) general areas: Screening Process, Eligibility Determination Process and Third Party Liability. Our preliminary findings from the Alliance Administrative Analysis also indicate that there is noncompliance with the contract, industry standards and best practices in these areas. More importantly, it appears that the process of according "Presumptive Eligibility" significantly contributes to these areas.

Presumptive Eligibility

The presumptive eligibility process was conceived and adopted as an operation method in which to comply with the following, somewhat contradictory, requirements:

1. Restructuring Plan For The Public Benefit Corporation, Pursuant To The Requirements of the Human Support Services Title Of The District of Columbia Appropriations Act: "The Goal of this plan is to provide the volume of medical services currently provided at the PBC to uninsured District residents."
2. Agreement Between The District of Columbia Financial Responsibility And Management Assistance Authority and Greater Southeast Community Hospital Corporation I: Exhibit A, 1.0 – Target Population, (Persons will be eligible for the D.C. Healthcare Alliance program if they meet the following criteria (the "Eligible Uninsured"): District of Columbia resident; lacks third party insurance and family income equal to or below 200% of federal poverty level. The contractor shall enroll eligible individuals into the program.") and
3. Agreement Between The District of Columbia Financial Responsibility And Management Assistance Authority and Greater Southeast Community Hospital Corporation I: Exhibit A, 5.0 – Administrative Services, 5.1 – Enrollment and Eligibility.

In order to provide the volume to the uninsured population and insure the appropriate eligibility requirements, a process to provide care while the presumed uninsured DC resident was conceived. The status presumptive eligibility takes place when the individual attests to the above 3 criteria for entry into the Alliance, but does not have documentation of the requirements. In order to process the individual and allow for uninterrupted services, he/she is **enrolled** into the program as "presumptively eligible" for 30 days, or until the individual can produce documentation of the eligibility criteria. The process for presumptive eligibility, as described on page 17 of the OIG report, is not entirely accurate in that the applicant is actually enrolled into the Alliance and given

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status within the system by assignment of an enrollment number and authorization to receive services as evidenced by retention of the "pink" copy of the application. This process creates administrative burdens that relate to many of the findings and recommendations made by the OIG.

Screening:

Eligibility and Enrollment: Requirements and Screening

The DC HealthCare Alliance program has specific eligibility requirements that are established by contract as well as services that are provided to particular populations. The following is a summary of these requirements and populations:

Alliance Program: Eligibility Table

Program	Description	Eligibility
Traditional DC HealthCare Alliance (Contract term: Exhibit A, 1.0)	▪ Provides comprehensive, integrated and coordinated health care services for the Eligible Uninsured population of the District.	1.) Resident of the District of Columbia, 2.) At or below 200% FPL, and 3.) Lacks Third-Party Insurance.
DC HealthCare Alliance – Corrections Health Care Services (Contract term: Exhibit A, 8.1)	▪ Provides health care and administrative services for prisoners in custody of the District of Columbia that are consistent with requirements established by the Department of Corrections and Youth Services Administration	1.) Prisoner in custody of the District of Columbia.
DC HealthCare Alliance – Health Care Services to Other District Agencies (Contract term: Exhibit A, 9.0)		
DC HealthCare Alliance – Metropolitan Police Department (MPD) Population	▪ Provides health care services comparable to the enrolled Eligible Uninsured population of the District.	1.) Individual in custody of the Metropolitan Police Department that requires health care services.

The above review of the Alliance population indicates that only the traditional Alliance population is subject to the 3 criteria. The Corrections population and the MPD population are also eligible for services under the Alliance and may be in the system with New Jersey or any other state residence if they are incarcerated in DC or in custody of MPD.

Regarding the use of inaccurate Social Security numbers (SSN), the current administrative process for enrolling individuals without SSN may account for the

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majority of these OIG findings. During our Administrative Analysis, we found that when an individual presented without a social security number, or couldn't remember it, the nine- (9) digit application number from the right upper corner of the completed document was entered into the SSN field. This application number is consistent with the findings as described in the OIG report. Typically, undocumented individuals are associated with this scenario. We have not had an estimate of the undocumented individuals within the Alliance recently, but it is not unlikely that over 2000 have presented and were determined eligible for services based on earlier reports, which is in alignment with the OIG reported number of invalid SSNs. The majority of the invalid SSNs are very likely related to this operational process.

Eligibility and Enrollment: Screening for Other Programs

The DC HealthCare Alliance program is the health care payer of last resort for health care services for the Eligible Uninsured in the District. By virtue of the eligibility requirements for the program, an individual must be screened for other public or private programs before eligibility in the Alliance is granted. The following is a summary of public programs and their eligibility requirements:

Alliance Program: Other Public Programs for Eligibility Screening		
Program	**Description**	Eligibility
Ticket to Work Demonstration	▪ Expands Medicaid eligibility for low-income people living with HIV who are working ▪ Targeted to D.C. residents who reside in Wards 7 and 8 (East of the Anacostia River) ▪ Limited program: will serve approximately 400 people living with HIV who are working	▪ Resident of Ward 7 or 8 ▪ Not eligible for traditional Medicaid ▪ HIV diagnosis ▪ At or below 300% FPL [$26,580 for a single adult and $45,060 for a family of three] ▪ Working 40+ hrs/month ▪ Assets - Savings below $4,000 single/ $6,000 couple - No property other than house client resides in and car
Medicaid Expansion (1115 Waiver)	▪ Expands Medicaid eligibility for low-income people living with HIV ▪ Limited program: will serve less than 300 people living with HIV	▪ DC resident ▪ Not eligible for traditional Medicaid ▪ HIV diagnosis ▪ At or below 100% FPL [$8,860 for a single adult and $15,020 for a family of three] ▪ Assets - Savings below $2,600

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		single/ $3,000 couple - No property other than house client resides in and single vehicle
Traditional Medicaid (Aged and Disabled)	▪ Inpatient and outpatient medical care, lab work, and prescription drugs ▪ People living with HIV usually do not qualify until diagnosed with AIDS	▪ DC resident ▪ Determined by Social Security Administration or IMA Medical Review Team to be disabled ▪ At or below 100% FPL [$8,860 for a single adult and $15,020 for a family of three] ▪ Assets - Savings below $2,600 single/ $3,000 couple - No property other than house client resides in and single vehicle
Traditional Medicaid/ DC Healthy Families (Pregnant women, parents and their children under 19)	▪ Inpatient and outpatient medical care, lab work, and prescription drugs ▪ Often enrolled in Medicaid managed care plans	▪ DC resident ▪ At or below 200% FPL [$17,720 for a single adult and $30,040 for a family of three]
AIDS Drug Administration Program (ADAP)	▪ Provides AIDS drugs to those individuals living with AIDS.	Per ADAP
Veteran's Administration	▪ Provides medical services to those eligible veterans of the Armed Services.	Per the VA
Workers' Compensation Fund	▪ Provides health care services to those who have been injured on the job or are otherwise eligible	Per Workers' Compensation Fund
Medicare	▪ Provides health care services to those eligible for covered, chronic services (dialysis for ESRD) and individuals >/= 65 y.o.	Per Medicare

Regarding the OIG screening recommendations #7 & #9, our findings also indicate that there are inconsistencies with the contractual requirements, industry standards or best practices in the areas of:

- consistency of application processing, eligibility determination and enrollment at the enrollment sites;

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- secondary eligibility and enrollment site performance;
- workflow across the involved units as related to application processing, eligibility determination, enrollment, and recertification;
- the screening processes that are in place for additional or alternative forms of health care coverage, particularly for Medicaid and HIV and AIDS services;
- the eligibility verification and business rules and practices for the corrections population and Metropolitan Police Department detainees that require medical services; and
- the overall processes for tracking presumptive eligibility.

These are our initial impressions from the Alliance Administrative Analysis regarding screening for eligibility. We plan to complete this process with a compliance analysis of the contract terms, industry standards, best practice comparisons and recommendations for corrective action and future contracting terms by October 25, 2002. Included in the corrective action requests will be: development of training policies and procedures, updates, appropriate internal quality assurance measures, and screening criteria and guidelines as infrastructure for the Alliance eligibility and enrollment screening. This will also include recommendations for managing the future of presumptive eligibility to adhere to the contractual requirements for Medicaid and third party payer eligibility and recoupment of cost.

We note that Chartered Health Plan, Inc. ("Chartered") provides direct oversight of this function and that initial training was provided at project inception. We recognized at project inception, there were a number of unclear process issues for enrollment specialists—and that this may be reflected in the adverse findings of the random selection of enrollee documentation. Nonetheless, the HCSNA will work with Chartered and the prime contractor, Greater Southeast Community Hospital Corporation, to develop more comprehensive, core training and scheduled in-service sessions addressing issues that continue to be problematic in the enrollment process. In tandem, the HCSNA will explore whether a partnership with the Income Maintenance Administration ("IMA") would better facilitate eligibility determinations.

With regard to current eligibility re-determinations, the policy is to make such determination every 6 months.

8. **Ensure that GSCHC establishes procedures to determine the Medicaid status of all applicants before admittance to the Alliance program is granted. In addition, recover all payments made by the Alliance for patients covered by the Medicaid program at the time health-care service was rendered and remit recovered funds to the District.**

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HCSNA Response: While the HCSNA would prefer that the Medicaid status of each Alliance applicant be determined prior to applicant's admittance into the Alliance program, the Contract and applicable regulations, as they now exist, do not require such verification prior to the provision of health care services. Rather the Contract and regulation provisions require only that the person not have Medicaid coverage (or other third-party medical or health insurance coverage) at the time of application or thereafter while receiving Alliance benefits. The HCSNA, Medicaid, the Income Maintenance Administration, and the Alliance are reviewing this issue to formulate a method to check Medicaid status prior to a determination of Alliance benefits that will be incorporated in a subsequent Contract modification and amendment to the applicable regulations.

Periodic comparisons are made between the Alliance membership rolls and the Medicaid rolls by a process called "bumping". As a result, over $520,000 in payments to Alliance providers has been refunded to the Alliance program from providers rendering services to individuals who were determined to be Medicaid eligible patients. To date, these repayments have been recouped by Chartered Health Plan, Inc., who reports the recoupments as credits on future invoices.

9. **Ensure that GSCHC determines that applicants for Alliance membership are not eligible for Medicaid coverage before Alliance eligibility is declared.**

HCSNA Response: While the HCSNA would prefer that Medicaid coverage be verified before Alliance eligibility is declared, neither the Contract nor the applicable regulations so require. As explained below, persons are entitled to Alliance membership even if it is later determined that Medicaid will pay for their health services. In the event of a subsequent Medicaid decision, the patient must be de-enrolled from the Alliance and recoupment of payments to the Alliance providers must be instituted.

The HCSNA is considering appropriate modifications to the Contract and the appropriate amendments to the applicable regulations to require verification of Medicaid status prior to a determination of Alliance eligibility. The HCSNA and Medicaid share a keen interest in assuring that a provider is not paid by both the HCSNA and Medicaid for the same service. Alliance program changes will be coordinated with the Alliance, Medicaid, and the Income Maintenance Administration to assure a continuum of patient care despite change in payer source.

Under the Contract and the applicable regulations as exist now, a person is entitled to Alliance membership if he/she does not have current insurance coverage (assuming residency and income requirements are met). Persons with pending Medicaid applications are eligible to receive health care services from Alliance providers unless and until an official determination by the Income Maintenance Administration has been made that the person qualifies for Medicaid.

"Health care services by private health care providers under contract with the District government may be available to persons who meet the following eligibility requirements:

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MANAGEMENT RESPONSE FROM THE DEPARTMENT OF HEALTH

[Deletion about residency and household income]
(c) The person does not have *coverage* by Medicaid or Medicare and does not have other third party medical or health insurance coverage."

See D.C. Mun. Regs. Tit. 22, § 3301.1 (Italics added).

The Contract, as modified, expressly provides as follows:

"Eligibility for the [Alliance] program for persons not in the custody or control of the Metropolitan Police Department at the time that Health Care Services are provided will be determined using the following criteria:
- District of Columbia resident;
- *Lacks third party insurance*; and,
  - Family income equal to or below 200% of the federal poverty level."

See Contract at Exhibit A, § 5.1.2.1 [Italics added].

"Once determined eligible [for the Alliance program], an individual not in the custody or control of the District of Columbia Metropolitan Police Department will be continuous and ongoing eligibility unless the individual:
- *Gains insurance coverage*;

[Deletion about loss of residency, fails to verify documents, or earns an income above 200% of the federal poverty level]"

See Contract at Exhibit A, § 5.1.4.1 [Italics added].

"Individuals who are *determined to have or be eligible* for other third party resources will not be eligible to receive Health Care Services under this [Alliance] program. In such case, the Contractor is expected to provide necessary services and submit invoices to such other appropriate payer for reimbursement."

See Contract at Exhibit A, § 5.4 [Italics added].

10. Require GSCHC to use a tax return. For those Alliance applicants who are required to file one, as proof of income and residence for Alliance insurance.

HCSNA Response: Utilizing tax returns does not present a viable and practicable option for income or residency.

As recognized by the Inspector General in his draft report, many Alliance applicants and participants earn an income less that the level required to file tax returns as an income of less than or equal to 200% of the federal poverty level is a requisite for the Alliance program. Requiring submission of tax returns for non-filers is a futile mandate burden, in light of the discussion below, that substantially outweighs the likely benefit to the District.

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Even if submitted, tax returns do not measure "household income" for Alliance eligibility as required by 22 D.C. Mun. Regs. § 3301.1(b). The term "household" is defined at 22 D.C. Mun. Regs. § 3399.1 to mean "individuals sharing a common residence as a single family unit including husband, wife, natural or adoptive parent, child or sibling; stepparent; stepchild; stepbrother; or stepsister." The filing units for federal and District tax returns do not utilize the concept of "household income" but rather measure income by taxpayer status such as individual, husband and wife, and head of household that do not reflect "household income" as defined for Alliance purposes.

Eligibility for the Alliance program is based on current income, not last year's income. *See* 22 D.C. Mun. Regs. § 3301.1(b). Tax returns show earned income and unearned income for a prior calendar year. Earning statements not older than thirty days more accurately establish current earned income and are authorized for submission. *See* 22 D.C. Mun. Regs. § 3301.1(b)(1)(A). Notably, the Income Maintenance Administration has advised that it does not require the submission of tax returns for current income screening for programs such as Medicaid.

Eligibility for the Alliance program is based on current residency, not last year's residency. Although a tax return may establish a person's residency at time of filing of the tax return, a person may legally change his residency after filing the tax return and be properly eligible for the Alliance program. *See* 22 D.C. Mun. Regs. § 3301.1. The HCSNA has been advised that the Income Maintenance Administration does not require submission of tax returns for proof of current residency for Medicaid applications.

Neither the Contract nor the applicable regulations specify the use of federal or District tax returns as mandatory tools of income verification. An applicant may voluntary choose to submit the first two pages of his/her District of Columbia tax return for the most recent tax year and/or a copy of his/her Federal income tax return for the most recent year as proof of income. *See* 22. D.C. Mun. Regs. §§ 3301.1(b)(1)(B, C) and 3301.1(b)(2)(C).

Given the time constraints that even the Inspector General encountered in reviewing the income tax return issue over many months, the HCSNA included the issue in its current Administrative Services Audit that is reviewing systems involved in the Alliance program. This Administrative Services Audit will make a recommendation regarding this issue.

11. **Review, periodically, Alliance membership rolls and ensure that enrollees meet all member requirements. Random sampling techniques may be employed.**

HCSNA Response: Membership rolls are periodically reviewed to assure that enrollees meet all eligibility requirements. No Alliance member is certified for longer than six months (as opposed to being certified for twelve months in the Medicaid program). As a result, each month, Greater Southeast Community Hospital Corporation, through Chartered Health Plan, Inc., is reviewing the membership rolls to assure members continue to meet all membership requirements consistent with the "regular assessment" requirement of Exhibit A, § 5.1.5.1 of the Contract.

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The six-month and annual reconciliation processes will examine membership rolls to verify if all enrollees meet membership requirements. The contractor who performed the first six-month reconciliation audit did not verify the requirements as its contract issued by the District of Columbia Financial Responsibility and Management Assistance Authority did not so require. Recognizing this shortcoming, the HCSNA has requested that the Office of Contracting and Procurement officially modify the auditor's contract to require verification of membership requirements.

The HCSNA and Greater Southeast Community Hospital have recently commenced discussions about random sampling techniques to verify enrollees meet eligibility requirement. Based on the findings of the second reconciliation report, the HCSNA may commence random samplings itself.

Finding I: Contract Oversight

Your report states that the Department has not provided the program oversight needed to assure the District government that contract goals are being met. You cite that contract oversight has been insufficient because DOH has failed to fill key oversight positions. In addition, DOH did not maintain a proper level of oversight regarding a consultant hired to assist HCSNA with contract oversight.

We take exception to this statement as presented. The following pages contain statements made in your report. Each statement will have a corresponding response as prepared by the HCSNA to either confirm or deny your findings.

OIG Report - Page 4, Paragraph 1

Appointed an outside commission, the Health Services Reform Commission (HSRC), to perform additional and independent contract oversight. (Contract oversight is discussed in Finding 1.)

HCSNA Response: The Commission was not formed to provide contract oversight. The HSRC was formed to monitor the transition, implementation and operation of the Health Services Reform (HSR). The Commission shall advise the Mayor of the District of Columbia, and the Chief Health Officer of the District of Columbia, on the progress and emerging challenges a the reform of the District's healthcare delivery system unfolds. (Mayor's Order 2001-74, May 16, 2001)

OIG Report - Page 4, Paragraph 2

District residents who are without health insurance coverage and whose family income is at or below 200 percent of the federal poverty level.

HCSNA Response: The contract with Greater Southeast Community Hospital also provides health benefits to two groups of people who may not fit the eligibility

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requirement under the contract for the general population. The contract provides for health care to the prison population. The population includes individuals who are not necessarily District residents and who may not fit the income requirements. The second group of people who receive health care under this contract who may not fit the eligibility requirements are those people brought in through the Metropolitan Police Department in custody. These individuals may also be residents of another state and may not fit the other eligibility requirements.

OIG Report - Page 5, Paragraph 2

The annual cost of the Contract is $79.5 million. $11.8 million for facility renovation.

HCSNA Response: In Tab 5 of the Agreement between GSCHC and the District, Page 3 of 3, Comparison of the Restructured Publicly-Financed Health Care Safety Net with Current Operations of the Public Benefit Corporation, a budget analysis for FY 02 encompasses the detail of the $90 million total costs for the contract. Although the analysis has been labeled FY 02, it really is talking about Contract Year 1.

The annual cost of the contract as stated in the OIG's report is $79.5 million. However, the fifth Exhibit I reflects a total budget of $81,605,327 for Contract Year 1. The health services amount of $59,175,039 is probably overstated in a sense that this was a start-up year and there would be some lag time in getting everyone used to the new concept in health care. There is no way you would have achieved these statistics in a start up year. Additionally, there was not a one time funding **payment** of $13.3 million ($11.8 million for facility renovation and $1.5 million for start-up support). There was a one time funding and a one time payment for $1.5 million for start up support, however, the $11.8 million was transferred to an account and payments are made based on approved invoices submitted for payment. To date, we have disbursed $3,689,389.44 for capital expenditures.

OIG Report - Page 5, Paragraph 3

The Table of Organization shows Howard as sub-contractor under Greater Southeast Hospital.

HCSNA Response: Howard is not a sub-contractor but a provider under the Greater Southeast Contract. The Prime contractor is GSCHC who has four sub-contractors which they call Partners. The Partners are Chartered Health Plan, Children's Hospital, Unity, and George Washington Hospital. All others are providers under the contract. Providers are brought into the network via a provider's agreement with Chartered Health Plan. Providence Hospital and Howard are providers in the network and should not be represented on this table of organization.

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OIG Report - Page 6, Paragraph 1

To accomplish our objectives, we examined financial reports, billing documents, program applications, invoices, and contracts.

HCSNA Response: The OIG received more than the above-mentioned documents to complete the audit. The HCSNA also provided the OIG with the following documents:

1. Contract Compliance Manual (Appendix 9)
2. Contract Compliance Assessment Tool (Appendix 10)
3. Contract Compliance Issues Log (contains items in the contract that require corrections) (Appendix 11)
4. HCSNA Strategic Plan
5. HCSNA Operational Plan
6. HCSNA Position Descriptions
7. The Weekly enrollment reports - from Chartered
8. Customer service reports - from Chartered
9. The ACC report Part I & II,
10. The Perinatal study from July 2001
11. The ED report from June 2001
12. The Koskinen reports.
13. Inpatient Daily Census Report (monthly) starting July 2001
14. The DCG ACC/ER Daily Activity Report

OIG Report - Page 7, Paragraph 1

DOH has failed to maintain a proper level of oversight regarding the Health Care Safety Net contract. This failure occurred because HCSNA did not fill key oversight positions. In addition, DOH did not maintain a proper level of oversight regarding a consultant hired to assist HCSNA with contract oversight. As a result, the District has little assurance that: (1) GSCHC is in compliance with all of the Contract terms; (2) the Contract goals are being met; (3) the estimated patient workloads reflected in the Contract are valid; and (4) the annual $79 million contract estimate is the correct amount to appropriate each year. In addition, DOH did not realize that the Alliance program could possible be over-funded by approximately $10 million. Further, DOH overpaid the consultant by $194,597 for travel expenses and paid for questionable services, which could total as much as $100,000.

HCSNA Response: The Health Care Safety Net Administration takes exception to this statement as presented. The information contained in this section titled "Finding 1: Contract Oversight" outlines how the Department maintains the proper level of oversight regarding the contract.

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OIG Report - Page 7, Paragraph 3

Ensure appropriate contractor infrastructure, ensure budget compliance by GSCHC and DOH. HCSNA would formally be charged with day-to-day responsibility for managing, monitoring, and evaluating the performance of GSCHC.

HCSNA Response: The HCSNA is not charged with the day-to-day responsibility for managing the performance of GSCHC. The HCSNA is charged with monitoring and evaluating the contract.

OIG Report - Page 8, Paragraph 1

The organizational structure of HCSNA was originally formulated as follows.

HCSNA Response: The HCSNA table of organization found in the OIG's report was a draft. The current table of organization can be found in Appendix 2.

OIG Report - Page 8, Paragraph 2

In May of 2001, DOH appointed a Deputy Director (MSS-16) to head HCSNA. During the next 6 months, only 2 positions under the Deputy were filled. The first was an Administrative Specialist (DS-12). The second position filled was a Special Assistant (DS-13).

HCSNA Response: The OIG's report does not depict the structure and associated hiring of the HCSNA staff correctly.

- Shauna Spencer, the first Director of the HCSNA, was not a Department of Health employee, but was on detail from DC General.
- During the first ten (10) months of the contract, there was no established Deputy Director position description through the DC Office of Personnel.
- In fact, when the current Director (Brenda Thompson) started, there were no Department of Health employees working in the HCSNA. Shauna Spencer, Director along with the two assistants were detailed employees from DC General.
- Under Brenda Thompson's leadership, all HCSNA positions were written and established through the D.C. Office of Personnel.
- Initially, Ms. Thompson served as the interim Director until a Director was found.
- Subsequently, Ms. Thompson was asked to take the position full time and was formally classified as Deputy Director of the HCSNA on April 1, 2002.
- Ms. Thompson wrote the position descriptions for the following HCSNA positions: Administrative Specialist, Program Analyst, Safety Net Systems Manager, Operations Manager, Reporting Analyst, Public Health Analyst, Clinical Quality Improvement Officer, Medical Records Technician and Facilities Manager. In addition Ms. Thompson is working on creating the following positions: Medical Director, Quality Improvement Specialist, Database Administrator, and Reporting Analyst (#2).

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Appendix 2 contains the staffing plan of the HCSNA. As indicated in the table, Ms. Thompson hired all employees of the HCSNA. Appendix 2 contains the position descriptions for the HCSNA.

OIG Report - Page 8, Paragraph 2

In addition, a consulting group was hired to work with HCSNA to develop reporting systems and perform studies for DOH, as needed.

HCSNA Response: The consulting group is called Mercer Consulting. Mercer was hired to do more than reporting systems development and perform studies. Mercer was hired to perform as staff of the HCSNA. They were to perform the day-to-day functions of the HCSNA until staff was hired and appropriately trained to perform in that capacity. Mercer was to transfer their knowledge to the new staff. Not only did Mercer have one full-time employee in the HCSNA, but also they had two .5 FTE working in the HCSNA. Also, the HCSNA had access to and used other staff in the Mercer Phoenix office as projects came up.

OIG Report - Page 8, Paragraph 2

However, key positions such as the Contract Compliance Agent, Clinical Director, and Community Services Director were never filled during this critical start-up stage of the Contract.

HCSNA Response: Neither the Contract Compliance Agent, Clinical Director, nor the Community Services Director were established positions with the DC Office of Personnel. After Ms. Thompson was hired, these position descriptions were created and submitted to personnel for processing. The DC Office of Personnel would not allow the use of the word "Director" for these positions as the use of this word required a different level of supervising, grade, and responsibilities.

Ms. Thompson informed the OIG investigators that under the current table of organization, the functions of the Clinical Director and Community Services Director were included in the position description for the Clinical Quality Manager and the Community Relations Specialist. The duties are the same.

OIG Report - Page 8, Paragraph 2

Contract Compliance Agent will provide financial, information systems and quality management expertise; develop DOH infrastructure for ongoing program operations;

HCSNA Response: Ms. Thompson also determined that the functions as contained in the Contract Compliance Agent's position description were not realistic. Therefore, oversight for contract compliance is contained in the Operation Manager's position description; with contract compliance being spread across several positions. Each

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position is responsible for a component of contract compliance as outlined in the contract compliance manual and assessment tool (both were provided to the OIG).

OIG Report - Page 9, Paragraph 2

The three critical oversight positions remained unfilled, and a revised HCSNA organizational chart, developed by the new Deputy, no longer reflects these key positions.

HCSNA Response: This statement is not true. The functions as contained in the position descriptions, were being carried out by Mercer staff. Ashish Abraham, M.D. served as the Clinical Manager and Cynthia Smith, R.N., J.D. served in various other capacities and worked in areas that relate to access to care issues, utilization, contract compliance and information systems. The Community Relations Specialist position was filled in February, 2002.

OIG Report - Page 10, Paragraph 1

In fact, with a staff of two, it was extremely difficult, if not impossible, for a Deputy Director to oversee and manage a contract as large, complex, expensive, and as important as the Health Care Safety Net contract.

HCSNA Response: See above response to page 9, paragraph 2. Mercer also provided staff and expertise in the following areas: database development, project management, technical writing support, and financial analysis support.

OIG Report - Page 10, Paragraph 3

When the Mayor appointed the 38-member HSRC in June 2001, the Commission promised that, in addition to DOH oversight, they too would actively oversee the Contract as part of a two-tiered approach established by the city to monitor contract compliance.

HCSNA Response: The Heath Services Reform Commission was not established to monitor contract compliance. See response to page 4, Paragraph 1.

OIG Report – Page 11, Paragraph 4

HCSNA Response: Estimated Annual Patient Workloads – The patient load volumes have increased significantly since these early volume numbers were released. Based on data for period May 2002 through August 2002 trended for a full 12 months, the following utilization will be realized by this program.

Inpatient	4,329 inpatient admissions
Emergency	17,475 encounters
Outpatient Clinic	92,208 visits

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OIG Report - Page 13, Paragraph 5

However, the hotline only operates Monday through Friday between 8:00 a.m. and 6:00 p.m. and is closed on weekends and holidays. When a call is placed to the toll-free number during "off hours, "an automated message instructs the participants to call a toll-free nurse-advice hotline.

HCSNA Response: See response to OIG Recommendation #6 on page 8 of this report.

OIG Report - Page 14, Paragraph 2

We found no written modifications to the Contract that allowed Chartered to operate the hotline less than 24/7. We believe that DOH and GSCHC violated the provisions of Title 27, DCMR § 3602.2.

HCSNA Response: See response to OIG Recommendation #6 on page 8 of this report.

Finding 2: Alliance Enrollment Screening Process

OIG Report - Page 16, Paragraph 1

Additionally, DOH provided little oversight to enforce enrollment contract provisions.

HCSNA Response: The HCSNA takes exception to this statement as presented. Refer to above paragraphs and stated attachments as presented recommendation 7 beginning on page 5.

OIG Report - Page 16, Paragraph 1

As a result, the Alliance incurred approximately $289,000 in medical charges for individuals having third-party insurance coverage and possibly incurred charges for individuals who are not District residents and dot not satisfy the income requirements.

HCSNA Response: See response to OIG recommendation #8 on page 14 of this report.

OIG Report - Page 16, Paragraph 3

The primary sites are Greater Southeast Community Hospital, D.C. General, and the six outpatient clinics run by the Alliance.

HCSNA Response: Service utilization is also rapidly increasing at Howard University Hospital and the Non-Profit Clinic Consortium.

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Other Matters of Interest

Trauma Services
HCSNA Response: Agree with OIG report

Emergency Room Visits
HCSNA Response: Agree with OIG report

Emergency Room Closures
HCSNA Response: Agree with OIG report

Average EMS patient preparation and transport time
HCSNA Response: The HCSNA does not have data on EMS patient preparation and transport times, therefore, we are not able to either confirm or deny this analysis. Due to the lack of this analysis, we strongly recommend that the last statement made in your report on page 27, "However, it is not unreasonable to assume that closure of D.C. General Hospital, to some extent, affected transportation time." should be deleted because there is no data to support this conclusion.

However, the HCSNA did conduct an assessment of ED wait times as contained in the following paragraphs. In early 2001, the District of Columbia began a monumental effort to transform a financially ailing safety net hospital and program into a financially viable and sustainable public-private enterprise that would improve the access to and quality of care provided to the District's uninsured residents.

One of the many challenging tasks that was a part of this privatization effort was the transformation of the full service, hospital-based emergency room at DC General to an effective free-standing Emergency Department and Urgent Care Center. As in any initiative of this magnitude, the initial phases of the transition were tumultuous. Early in the transition process, the HCSNA recognized that accurate and timely information on ED performance would be critical to the identification of issues of concern and ensuring continuous improvement in the quality of care provided.

Towards this end, the HCSNA and its consultants implemented a focused ED monitoring and reporting initiative. The first step in this initiative was to solicit the collaborative participation of the ED administrative and clinical staff, Alliance leadership and other stakeholders. Through frequent meetings with this group, a set of critical indicators of ER operations and performance were identified and a reporting template that incorporates these indicators was developed. Once this template was established, a reporting methodology was implemented that sought to capture the required information accurately and transmit the data to the DOH on a daily basis. The process for reporting was linked to an appropriate training program for administrative staff. Within a few weeks of the implementation of these initiatives, data was being transmitted to the DOH and this was then compiled into detailed reports that were circulated to key internal and external stakeholders on a weekly basis. Since the early phases, the quality and accuracy of data reporting has improved significantly and the manual processes used initially have been

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and continues to be automated to assist in this process. The reports prepared by the team of monitoring staff have been instrumental in identifying opportunities for improvement.

One such area of focus has been the issue around wait times in the ED. Based on the information provided through the daily reports, it was determined that a significant number of patients were waiting for more than 6 hours in the ED. A review of national data sources revealed a national benchmark statistic for this indicator that was presented in the reports to compare HCSNA performance. The reports also identified key reasons for these prolonged waits which allowed DCHCA staff to implement targeted interventions. The steps taken to address these issues have resulted in dramatic decreases in the time spent by patients in the DC General ED. For example since December of 2001, the average number of patients waiting more than 6 hours has decreased by almost 200% from a high of 19.8% to a low of 11% in March. Other indicators of performance have also improved despite increases in ED patient volume.

The results of this initiative clearly validate the positive impact of data reporting to identify and address issues of concern. The results also demonstrate the value of collaborative partnerships between the District HCSNA and Alliance staff to improve the quality of care provided to D.C.'s uninsured residents and it is hoped that this spirit of collaboration will continue to be strengthened in the days to come.

EXHIBIT D

WILLIAM M. MERCER RESPONSE TO THE DRAFT REPORT

MERCER
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September 30, 2002

Mr. William J. DiVello
Assistant Inspector General for Audits
Office of the Inspector General
717 14th Street NW
Washington, DC 20005

Subject:
OIG No. 02-1-2HC

Dear Mr. DiVello:

Thank you for providing Mercer Human Resource Consulting (Mercer) the opportunity to comment on the above-referenced draft report. My comments will be primarily limited to those statements contained in the report that are directly in reference to Mercer.

However, before providing those comments, I would also like to comment on the finding that the Department of Health (DOH) failed to maintain the proper level of contract oversight because positions were not filled in a timely manner. The task faced by DOH, and the timeframe available to accomplish it, was significantly more complex than the need for additional staffing would have addressed at the time. The DOH aggressively and tirelessly worked in partnership with the District of Columbia Healthcare Alliance (Alliance) to rapidly develop a community-based system of care capable of safely transitioning and effectively treating nearly 30,000 individuals in need of healthcare. The outcome of that short-term objective was undeniably successful.

Given that this needed to be accomplished in a matter of weeks rather than months required that the DOH focus on short-term priorities, while beginning the longer term process of fully developing an effective oversight and management system. This is in no way a failure, rather it is an effective strategy for ensuring the safety and ongoing medical care of the people they are responsible for serving and the community at large. In effect, this was an exercise of riding the bicycle and changing the tire at the same time. The immediate needs and safety of the eligible population always came first and many activities in the first six months required that DOH keep their oversight focus on those issues. However, at the same time, work was also ongoing with regard to capturing and analyzing financial and medical service data, developing contractor reporting requirements, building a data warehouse, creating a contract monitoring tool, reviewing

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MERCER
Human Resource Consulting

policies and procedures, designing and implementing a systematic structure and process for continually improving the system, and a number of other activities, which were all occurring throughout the first year of operation. What the DOH did, in a very short period of time, was create an entirely new organization where none had existed before. The task was, and remains, complex and demanding. The DOH and the Alliance have done an outstanding job in completing the first phase in what is realistically a multi-year process of changing the face of the healthcare system for the uninsured population in the District of Columbia (District). Should the City Council and the Mayor feel confident that phase one has been a success and that the system of care and the system of oversight continue to mature and improve? Absolutely.

During the initial months of the Health Care Safety Net Administration (HCSNA) and Alliance start up, everyone involved in the project needed to act in a flexible manner to meet the emerging issues of the day while keeping focus on the longer term objectives. Mercer staff did so in an effort to provide the staff support that the District needed in a manner that best met the Director's needs at the time. With regard to contract oversight as it relates to Mercer, the amount of oversight and direction that Mercer experienced under this contract was greater than with that typically provided under other District and other state contracts held.

With regard to Mercer, the report, as written, is of great concern. Although one investigator associated with collecting information was provided documentation and information regarding the staffing to be provided by Mercer, that information is not fully reflected in the report. It is also of concern that, while Mercer readily provided all information requested, there was little to no direct follow-up discussion with regard to any concerns the IG staff may have had.

The report indicates that Mercer was to provide three full-time onsite staff to the HCSNA. That is not accurate. The proposal Mercer submitted to the DOH and the Authority was the basis for funding the contract and clearly specified that Mercer would provide two staff and up to 300 hours for a project manager. In addition, in a previously provided November 7 2001 email to me, the then HCSNA Director confirms that, in addition to redirecting several other contract tasks, that one position originally intended to be hired by Mercer would, in fact, be provided by the District. Therefore, the onsite staffing requirement was revised from two full-time positions to one. The third referenced position is, and always has been, a partial position for which Mercer has more than fulfilled the requirement. In addition, between the period of June 2001 and September 2001, Mercer provided DOH an average of 7.4 full-time employees (FTE) including

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both on and offsite support. While the report appears to focus on the staffing associated with only task four, a more complete and accurate understanding of the level of support provided by Mercer can be obtained by looking at staffing provided for all tasks. Staffing did vary from the original proposal, however, the proposal clearly indicated that staffing hours by task were estimates and subject to change. Some tasks required more time and some less, but the staffing requirement was met and any changes in focus were made in collaboration with the HCSNA Director to best meet the needs of the District.

The report also indicates that DOH overpaid Mercer by $194,597 for travel expenses. The basis for this claim is that the contract contains a line item of $50,000 per year for travel. While it is true that there is such a line in the budget, that amount was provided as an estimate only and did not anticipate the significant ongoing demand for onsite staffing support. This additional demand was created by the requests to change the focus of some tasks to include more onsite reviews and day-to-day support, as well as issues related to interacting with multiple data systems instead of one, as was originally anticipated.

While the contract does contain a $50,000 estimate for travel expenses, the contract also contains the following clause in Article IV: **"The Contractor shall be reimbursed for its reasonable actual out-of-pocket expenditures in connection with this Agreement for travel costs under this Agreement. Requests for reimbursement of costs shall be incorporated into the invoices to be submitted to the Authority and shall include copies of all invoices for which reimbursement is requested."**

In addition to this language, Mercer had specific discussions with representatives of the Authority at the time the contract was being finalized, and was assured that as long as the total amount of the contract was not exceeded, there would be flexibility to vary expenses among and between the budget estimates contained in the contract. At no time was the total authorized budget exceeded and, in fact, Mercer came in under budget during the period of May 2001 to September 2001. Finally, Mercer submitted its travel and expense reports as required by the contract and they were systematically reviewed and approved by the DOH. Mercer does not believe the statement regarding overpayment for travel and expenses is accurate and respectfully requests that it be modified to more accurately depict the situation. To do otherwise is misleading and will create unfounded and unnecessary concern. Mercer did nothing inappropriate and only acted in good faith to provide the support requested by our client.

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WILLIAM M. MERCER RESPONSE TO THE DRAFT REPORT

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Finally, the report suggests that the DOH may have overpaid Mercer for services by as much as $100,000. Based upon the information provided in the report, it is not possible to determine the basis for this claim. Apparently, an investigator attempted to reconcile travel expense reports and billed hours and concluded that the two did not coincide. Based on the data we believe the investigator reviewed, it is likely that such an analysis would not provide a complete picture. It also appears that the focus of this analysis was limited to charges related to task four only. By limiting the analysis to this single item, staff time from the same people and others working on other tasks is lost.

As previously mentioned, on average, Mercer provided 7.4 FTE to DOH from June 2001 through September 2001. In May 2001, 4.38 FTE were provided; in June 2001, 5.33 FTE; and in August 2001, 7.34 FTE supported the initiative. In September 2001, largely due to the programming work associated with the data warehouse, Mercer actually provided its highest level of staffing at 12.92 FTE. It should also be noted that the staff provided by Mercer possessed specialized skill sets including medical, financial, nursing, and information systems design, and staff had extensive experience in the health care and government field of service. These specialized skills could not have been recruited and placed into District positions in the time allowed.

While we may well have been able to provide the level of detail being sought, it was not requested. Mercer's request to see the workpapers associated with this analysis so we could help clarify whatever questions the investigator was left with was denied, with staff indicating it is against IG policy, but we could meet or ask questions. With only four working days to respond to this report, submitting questions was not a viable solution. As a result, we cannot determine any basis for this conclusion. Mercer can only assure the District that all services billed were done at the request of the client under the authority of a valid contract. Since there does not appear to be a way to substantiate this conclusion, Mercer respectfully requests that it be deleted from the report, or that an alternative substantiated concern be addressed.

EXHIBIT D

WILLIAM M. MERCER RESPONSE TO THE DRAFT REPORT

MERCER
Human Resource Consulting

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Again, thank you for the opportunity to respond to the draft report. It is our sincere desire that the requested changes to the report be made before it is finalized or distributed.

If you have any questions regarding this response or need any additional information, please do not hesitate to contact me at 602 522 6508.

Sincerely,

Charles P. "Chip" Carbone

CC/tl

Copy:

Mr. James Buford
Mr. John Koskinen, City Administrator
Ms. Brenda Thompson